TEEN PREGNANCY PREVENTION (TPP) PROGRAMS

RESOURCES FOR REQUEST FOR APPLICATION

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8. **Youth Development Reader. California Department of Health Services. Leadership Conference, April 2001.**

9. **Additional Teen Pregnancy Prevention Articles and Websites**

    - **US Teenage Pregnancy Statistics with Comparative Statistics for Women Aged 20-24. The Alan Guttmacher Institute. 2004**
    - **US Teenage Pregnancy Statistics, Overall Trends by Race and Ethnicity and State-by-State Information. The Alan Guttmacher Institute. 2004**
    - **Young Men Moving Forward. California's Male Involvement Program. A Teen Pregnancy Prevention Program for Males.**

Adolescent Family Life Program Directory. California Department of Health Services, Maternal and Child Health Branch. February 2004

Adolescent Family Life Program DIRECTORY

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2/04

ADOLESCENT FAMILY LIFE PROGRAM

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ADOLESCENT FAMILY LIFE PROGRAM

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ADOLESCENT FAMILY LIFE PROGRAM

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ADOLESCENT FAMILY LIFE PROGRAM

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ADOLESCENT FAMILY LIFE PROGRAM

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ADOLESCENT FAMILY LIFE PROGRAM

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ADOLESCENT FAMILY LIFE PROGRAM

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ADOLESCENT FAMILY LIFE PROGRAM

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ADOLESCENT FAMILY LIFE PROGRAM

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ADOLESCENT FAMILY LIFE PROGRAM

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ADOLESCENT FAMILY LIFE PROGRAM

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"*Summary*: Emerging Answers. Research Findings on Programs to Reduce Teen Pregnancy." Douglas Kirby, Ph.D. The National Campaign to Prevent Teen Pregnancy. May 2001.

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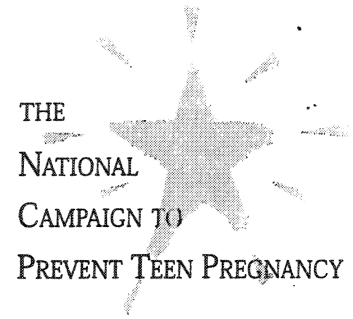
Summary



Emerging Answers

Research Findings on Programs to Reduce Teen Pregnancy

Douglas Kirby, Ph.D.

May 2001

Foreword

As Doug Kirby notes in his Author's Preface (p. v), much has changed for the better in the four years since the National Campaign published his first review of evaluation research on programs to prevent teen pregnancy, *No Easy Answers*, in 1997. Teen pregnancy and birth rates have been steadily declining, efforts to prevent teen pregnancy at both the national and local levels have increased, and, as this report shows, the quality of evaluation research in this field has improved, bringing with it clear evidence that several different kinds of programs can reduce teen sexual risk-taking and pregnancy. This is good news for all of us who care about young people — and about the next generation of children who deserve to be raised by adult parents.

From our founding in 1996, the National Campaign has believed that "getting the facts straight" is critically important in our field — a field that is subject to so much controversy and conflict. Under the guidance of the National Campaign's Task Force on Effective Programs and Research (EPR), which Dr. Kirby chairs, we have published a series of research reports on

such topics as parental and family influence in adolescent sexual behavior, the role of peers in teens' sexual decision-making, and the effectiveness of media campaigns. However, the National Campaign's most requested research publication by far has been Dr. Kirby's *No Easy Answers*, which is a testament both to the quality of his work and to the intense interest among program developers and political leaders alike in finding out "what works." I anticipate that his long-awaited update of the research, with the more hopeful title of *Emerging Answers*, will prove to be as influential and popular as its predecessor. This pamphlet offers a summary of the full, 200-page report, which is also available from the National Campaign.

On behalf of the National Campaign, I would like to express our great appreciation to Doug Kirby for producing this excellent research review. We commend him for his diligence in searching high and low for relevant studies (published and unpublished), for his unwavering commitment to being fair and evenhanded in his assessment of the research, for his meticulous attention to detail, and, most of all, for his great wisdom and good humor throughout an extensive process of review and editing. We also extend our deep appreciation to the National Campaign's Task Force on Effective Programs and Research (see the list of members after the title page), a distinguished and diverse group of researchers and experts, under whose auspices this review was developed.

It should be noted here that Doug Kirby, who is a Senior Research Scientist at ETR Associates, has a well-deserved reputation as a high-quality evaluation researcher himself, and, as a consequence, a number of his own studies of programs appear in this review. In addition, in the interest of full disclosure, Dr. Kirby thought it was important to make it clear that ETR Associates, a nonprofit organization that provides educational resources, training, and research in health promotion, developed the *Reducing the Risk* and *Safer Choices* curricula, two of the sex and HIV education programs this review concludes have the strongest evidence of effectiveness. ETR Associates continues to market these curricula. In addition, several members of the National Campaign

Task Force on Effective Programs and Research were also involved in some of the studies reviewed in this report.

Although we believe that having accurate, research-based information can only help communities make good decisions about preventing teen pregnancy, the National Campaign recognizes that communities choose to develop particular prevention programs for many reasons other than research — including, for example, compatibility with religious traditions, available resources, community standards, and the personal values and beliefs of the leaders in charge. In this context, I would add that it is crucial for such leaders to understand that community-based programs are only part of the solution to the teen pregnancy challenge and that no single effort can be expected to solve this problem by itself. Teen pregnancy is, after all, a very complex problem, influenced by many factors, including individual biology, parents and family, peers, schools and other social institutions, religion and faith communities, the media, and the list goes on. In an ideal world, we would mount efforts to engage the help of all these forces, particularly popular culture, schools, faith communities, parents, and other adults. But we are a long way from doing so, and many communities mistakenly believe that modest community programs can do this single-handedly. In many instances, these programs are fragile and poorly-funded; even apparently "effective" programs often achieve only modest results; and not all teens at risk of pregnancy are enrolled in programs. The simple point is that no single approach can solve this problem alone, whether it be a national media campaign, a new move in faith communities to address this problem, or a well-designed community program. Advocates of any single approach — especially, in the context of this review, community programs — should therefore be modest in both their promises and their expectations.

In the final analysis, professionals working with youth should not adopt simplistic solutions with little chance of making a dent on the complex problem of teen pregnancy. Instead, they should be encouraged by declining rates and new research showing that some programs are making a difference. They should continue to explore many ways to address the various causes of

teen pregnancy. They should replicate those programs that have the best evidence for success, build their efforts around the common elements of successful programs, and continue to explore, develop, and evaluate innovative and promising approaches.

Sarah Brown
Director
National Campaign to Prevent Teen Pregnancy
May 2001

Author's Preface

In 1997, I wrote *No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy* for the National Campaign to Prevent Teen Pregnancy. At that time, with only a few exceptions, most studies assessing the impact of programs to reduce teen sexual risk-taking failed either to measure or to find sustained long-term impact on behavior. Among the few programs that appeared to have longer-term impact, none had been evaluated two or more times by independent researchers and found to be effective. Indeed, the two replications of programs that had previously shown positive effects on behavior failed to corroborate those initial positive findings. In general, the research evidence indicated that there were "no easy answers" to markedly reducing teen pregnancy in this country.

Now, four years later, the research findings are definitely more positive, and there are at least five important reasons to be more optimistic that we can craft programs that help to reduce teen pregnancy. First, teen pregnancy, abortion, and birth rates began to decrease about 1991 and have continued to decline

every year since then. Not only have these rates maintained their downward trend, but teen birth rates are now at their lowest recorded level ever. Second, larger, more rigorous studies of some sex and HIV education programs have found sustained positive effects on behavior for as long as three years. Third, there is now good evidence that one program that combines both sexuality education and youth development (i.e., the *Children's Aid Society-Carrera Program*) can reduce pregnancy for as long as three years. Fourth, both service learning programs (i.e., voluntary community service with group discussions and reflection) and sex and HIV education programs (i.e., *Reducing the Risk*) have now been found to reduce sexual risk-taking or pregnancy in several settings by independent research teams. Fifth, there is emerging evidence that some shorter, more modest clinic interventions involving educational materials coupled with one-on-one counseling may increase contraceptive use. All of these findings are most encouraging. Of course, it is still very challenging to design or operate programs that actually reduce adolescent sexual risk-taking and pregnancy over prolonged periods of time. However, we now know it is possible, and we have clearer guidelines for how to do it.

The report that this pamphlet summarizes is, in many respects, a second edition of *No Easy Answers*. Much of the content and organization remains the same. However, the methodological criteria for inclusion of studies has changed, more studies have been reviewed, and there are important new findings. Given the stronger and more consistent research findings demonstrating program effectiveness, we have entitled it *Emerging Answers*.

Douglas Kirby, Ph.D.
May 2001

Summary

Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy

Introduction

When the National Campaign to Prevent Teen Pregnancy released its first major report, *No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy* (Kirby, 1997), it wasn't clear that the recent modest reductions in rates of teen pregnancy and childbearing noted at the time were going to continue. Four years later, there is good news to report: teen pregnancy and childbearing rates have continued their significant decline for several years among all racial and ethnic groups and in all parts of the United States. The credit for this welcome trend goes, of course, to teens themselves who have obviously changed their behavior for the better. Evaluation research completed since *No Easy Answers* was published offers additional good news: more programs to prevent teen pregnancy are making a real difference in encouraging teens to remain abstinent or use contraception when they have sex. As a result of these encouraging trends in the rates and in the research, this updated research review is entitled *Emerging Answers.*

However, what was true in 1997 is still true today: teen pregnancy and childbearing remain very serious problems in the United States. Even with recent declines, the United States still has the highest teen pregnancy and birth rates among comparable industrialized nations, twice as high as Great Britain and ten times as high as the Netherlands, for instance. In other words, this is no time to be complacent; there's still a long way to go.

Not surprisingly, people from all over the country still come to the National Campaign with one principal question: "What can I do in my community to prevent teen pregnancy — what really works?" This new research review helps answer that question more definitively. However, it is important from the outset to note some of its limitations. The full report, which is summarized here, discusses only those programs that have been subjected to evaluation research that meets certain methodological criteria (see below). It does not discuss what parents can do; it does not evaluate the role of broad cultural values and norms; and it does not review the relative efficacy of various methods of contraception. And the paper examines only primary prevention programs; it does not review interventions to prevent second pregnancies and births among teen mothers, although some of the conclusions would apply to these pregnancies and births as well. In addition, it is crucial for leaders to understand that although effective programs can help reduce teen pregnancy — a few quite substantially — it is naive to think that they can completely solve the problem by themselves. Indeed, no single approach to preventing teen pregnancy can provide a 100% solution.

Nonetheless, prevention programs can be an important part of the answer, and it is encouraging that research is revealing more about what makes the successful ones work. The research reviewed here offers some important "emerging answers" about what effective programs look like. It summarizes what has, and has not, worked in many communities. Of course, local decisions about programming are often affected by more than research, including such important considerations as community values, available resources, complementary services already available, the preferences of teens and parents, and local politics. Fortunately, a number of manuals to help communities put all these pieces

together are available, including the National Campaign's *Get Organized: A Guide to Preventing Teen Pregnancy.*

The following summary outlines some facts that explain why communities must remain vigilant about teen pregnancy, childbearing, and STDs, outlines the criteria for including studies in this review, discusses some of the antecedents of teen sexual risk-taking, and, finally, summarizes the findings of the research review and their implications for communities.

The Problem of Teen Pregnancy

The recent and steady decline in teen pregnancy and birth rates in the United States should provide encouragement that continued progress is possible. However, there remain compelling reasons to increase prevention efforts:

- Despite the declining rates, more than four in ten teen girls still get pregnant at least once before age 20, which translates into nearly 900,000 teen pregnancies per year.
- Despite a leveling off of sexual activity among teens, about two-thirds of all students have sex before graduating from high school — potentially exposing themselves to pregnancy and STDs.
- When teens give birth, their future prospects become more bleak. They become less likely to complete school and more likely to be single parents, for instance. Their children's prospects are even worse — they have less supportive and stimulating home environments, poorer health, lower cognitive development, worse educational outcomes, more behavior problems, and are more likely to become teen parents themselves.
- Despite indications of better use of contraception by sexually active teens (particularly of condoms at first sex), many do not use contraceptives correctly and consistently every time they have sex.
- As a result of sexual risk-taking, about one in four sexually experienced teens contract an STD each year — some of

which are incurable, including HIV, which is, of course, life-threatening.

- Despite recent encouraging trends in teen pregnancy, it is important to remember that each year a new set of teens arrives on the scene, meaning that efforts to prevent teen pregnancy must be constantly renewed. In addition, between 2000 and 2010, the population of teen girls aged 15-19 is expected to increase by nearly 10 percent — which means that even declining *rates* may not necessarily mean fewer *numbers* of teen pregnancies and births.

The Criteria for Inclusion in this Review

Evaluation studies included in *Emerging Answers* had to meet certain scientific criteria. While *No Easy Answers* used publication in a peer-reviewed journal as the primary qualification for including a study, this review relies on an expanded set of methodological criteria. This change was made for two reasons: (1) some studies employed rigorous research methods but, for a variety of reasons, were never published in peer-reviewed journals, and (2) a few studies published in peer-reviewed journals employed very weak methods and provided misleading results. To be included in *Emerging Answers*, a program evaluation had to meet multiple criteria, the most important of which were to have:

- been completed in 1980 or later,
- been conducted in the United States or Canada,
- been targeted at adolescents of middle school or high school age (roughly 12-18),
- employed an experimental or quasi-experimental design,
- had a sample size of at least 100 in the combined treatment and control group, and
- measured impact on sexual or contraceptive behavior, pregnancy, or childbearing.

Antecedents to Sexual Risk-Taking, Pregnancy, and Childbearing

The reasons behind teen pregnancy are complex, varied, and overlapping. In fact, from a review of at least 250 studies, *Emerging Answers* culls more than 100 precursors or "antecedents" to early teen sexual intercourse, poor contraceptive use, pregnancy, and childbearing. These risk factors fall under such categories as community disadvantage; family structure and economic disadvantage; family, peer, and partner attitudes and behavior; and characteristics of teens themselves, including biology, detachment from school, other behaviors that put young people at risk, emotional distress, and sexual beliefs, attitudes, and skills. While all teens are at some risk, some teens are at much higher risk than others. These antecedents can be used to identify those youth at higher risk of sexual risk-taking and to guide the development of effective programs. No single program could — or should — try to address all of these antecedents; yet, at the same time, effective programs are more likely to focus intentionally on several of them in a clear, purposeful way.

Because the reasons behind teen pregnancy vary, so do the types of programs adults design to combat the problem. When most people think of preventing teen pregnancy, they probably conjure images of sex or abstinence education classes or clinics that offer contraceptive services. Although the most important antecedents of teen pregnancy and childbearing relate directly to sexual attitudes, beliefs, and skills, many influential family, community, cultural, and individual factors closely associated with teen pregnancy actually have little to do directly with sex (such as growing up in a poor community, having little attachment to one's parents, failing at school, and being depressed). In fact, one program with strong evidence for success in reducing teen pregnancy concentrates on the *non-sexual* antecedents of teen pregnancy. Simply put, the antecedents to teen pregnancy come in two categories: those that are sexual in nature (such as attitudes toward sex and contraception) and those that are not.

Findings on Programs

With these two categories of antecedents in mind, one can divide programs to prevent teen pregnancy into three types: those that focus on sexual antecedents, those that focus on non-sexual antecedents, and those that do both. *Emerging Answers* organizes its findings on programs into these three broad categories — and then into several sub-categories — and offers conclusions about the research in each. Of course, given the great diversity of programs that exist, any typology will be inadequate to the task of capturing all the various ways that programs can be defined.

Programs That Focus on the *Sexual Antecedents* of Teen Pregnancy

Curricula-Based Programs

- Abstinence-Only Programs
- Sex and HIV Education Programs

Sex and HIV Education Programs for Parents and Families

Clinic or School-Based Programs to Provide Reproductive Health Care or to Improve Access to Condoms or Other Contraceptives

- Family Planning Clinics and Services
- Protocols for Clinic Appointments and Supportive Activities
- Other Clinic Characteristics and Programs
- School-Based and School-Linked Clinics
- School Condom-Availability Programs

Community-Wide Initiatives with Many Components

Programs That Focus on *Non-Sexual* Antecedents

Early Childhood Programs

Youth Development Programs for Adolescents

- Service Learning Programs
- Vocational Education and Employment Programs
- Other Youth Development Programs

Programs That Focus on *Both* Sexual and Non-Sexual Antecedents

Programs with Both Sexuality and Youth Development Components

Programs that Focus on Sexual Antecedents of Teen Pregnancy

Programs that focus on the sexual antecedents of teen pregnancy are divided in this review into four groups: curricula-based programs for young people (including abstinence education and sex education) that are typically offered in schools, sex and HIV education programs for parents and families, programs to improve access to condoms and other contraceptives, and multi-component, community-wide initiatives that have a strong emphasis on sex education or contraceptive services.

Curricula-Based Programs

According to recent national surveys, nearly every teenager in this country receives some form of sex or abstinence education, but the curricula vary widely in both focus and intensity. This review places curricula into two groups: abstinence-only education and sex or HIV education (sometimes also called abstinence-plus or comprehensive sex education). There has been a great growth in the former category since the 1996 welfare reform law made $85 million in federal and state funding available each year for abstinence-until-marriage interventions. However, in practice, curricula-based programs don't really divide neatly into these two groups; they actually exist along a continuum. For instance, while all abstinence-only programs focus on abstinence as the only truly healthy and correct choice for young people, some also discuss condoms and other contraception, focusing primarily on their failure rates; others mention the protective uses of condoms in a medically accurate manner, while still stressing abstinence. Similarly, many sexuality education programs describe abstinence as the safest, and often the best, choice for teens but also encourage the use of condoms and other contraception for sexually active teens. A few — particularly those for high-risk, sexually active youth — focus primarily on consistent use of contraceptives, especially condoms.

Abstinence-Only Programs

Very little rigorous evaluation of abstinence-only programs has been completed; in fact, only three studies met the criteria for this review. The primary conclusion that can be drawn from these three studies is that the evidence is not conclusive about abstinence-only programs. None of the three evaluated programs showed an overall positive effect on sexual behavior, nor did they affect contraceptive use among sexually active participants. However, given the paucity of the research and the great diversity of abstinence-only programs that is not reflected in these three studies, one should be very careful about drawing conclusions about abstinence-only programs in general. Fortunately, results from a well-designed, federally-sponsored evaluation of Title V-funded abstinence programs should be available within the next two years.

Sex and HIV Education Programs

A large body of evaluation research clearly shows that sex and HIV education programs included in this review do not increase sexual activity — they do not hasten the onset of sex, increase the frequency of sex, nor increase the number of sexual partners. To the contrary, some sex and HIV education programs delay the onset of sex, reduce the frequency of sex, or reduce the number of sexual partners. In fact, since the publication of *No Easy Answers*, two independent studies have found that one particular curriculum, *Reducing the Risk*, delayed the onset of intercourse. (*Reducing the Risk* also increased the use of condoms or contraceptives among some groups of youth). This is the first time that research on replications of a sex education program has confirmed initial findings of effectiveness.

Other sex and HIV education programs — including *Safer Choices; Becoming a Responsible Teen; Making a Difference: An Abstinence Approach to STD, Teen Pregnancy, and HIV/AIDS Prevention*; and *Making a Difference: A Safer Sex Approach to STD, Teen Pregnancy, and HIV/AIDS Prevention* — have also been shown to delay sex or increase condom or other contraceptive use and thereby to decrease unprotected sex substantially.

The studies of these four curricula employed experimental designs and found positive behavioral effects for at least 12 to 31 months. All five of these sex and HIV education curricula have also been identified by the Centers for Disease Control and Prevention (CDC) as having strong evidence of success.

The programs that have changed teens' sexual behavior share ten necessary characteristics (see sidebar on the next page). The absence of even one of these characteristics appears to make a program appreciably less likely to be effective.

Sex and HIV Education Programs for Parents and Families

Most parents want to impart their values about sexuality to their children. But because parents often have difficulty talking with their children about sexual topics, a number of educational programs have been developed to improve parent/child communication. Many studies have demonstrated short-term increases in parent/child communication, as well as increases in parent comfort with that communication, although the positive effects dissipate with time. Neither of the two studies that measured whether these programs delayed the onset of sexual intercourse found statistically significant effects, but the characteristics of the studies might have obscured possible program impact. This does not mean that parental influence and parent/child communication are not important. In fact, other research confirms the importance of parent/child "connectedness," for instance, in reducing risky sexual behavior among teens.

Programs Designed to Improve Access to Condoms or Other Contraceptives

Many community family planning clinics, school-based health clinics, and school-linked clinics offer services to teens, including access to condoms and other contraceptives. With regard to family planning clinics in particular, it is clear that they provide many adolescents with contraceptive services, which presumably prevent pregnancies among those teens. Nonetheless, because the long-term impact of family planning services on the frequency of sexual behavior is not known, the number of teen

10 Characteristics of Effective Sex and HIV Education Programs

The curricula of the most effective sex and HIV education programs share ten common characteristics. These programs:

1. Focus on reducing one or more sexual behaviors that lead to unintended pregnancy or HIV/STD infection.
2. Are based on theoretical approaches that have been demonstrated to influence other health-related behavior and identify specific important sexual antecedents to be targeted.
3. Deliver and consistently reinforce a clear message about abstaining from sexual activity and/or using condoms or other forms of contraception. This appears to be one of the most important characteristics that distinguishes effective from ineffective programs.
4. Provide basic, accurate information about the risks of teen sexual activity and about ways to avoid intercourse or use methods of protection against pregnancy and STDs.
5. Include activities that address social pressures that influence sexual behavior.
6. Provide examples of and practice with communication, negotiation, and refusal skills.
7. Employ teaching methods designed to involve participants and have them personalize the information.
8. Incorporate behavioral goals, teaching methods, and materials that are appropriate to the age, sexual experience, and culture of the students.
9. Last a sufficient length of time (i.e., more than a few hours).
10. Select teachers or peer leaders who believe in the program and then provide them with adequate training.

Generally speaking, short-term curricula — whether abstinence-only or sexuality education programs — do not have measurable impact on the behavior of teens.

pregnancies prevented by family planning services is difficult to estimate.

However, there are clearer findings regarding particular clinic protocols or programs within health or family planning clinics. These programs — in which youth were provided with information about abstinence, condoms, and/or contraception; were engaged in one-on-one discussions about their own behavior; were given clear messages about sex and condom or contraceptive use; and were provided condoms or contraceptives — consistently increased the use of condoms and contraception without increasing sexual activity.

Many studies of schools with health clinics and schools with condom-availability programs have consistently shown that the provision of condoms or other contraceptives through schools *does not* increase sexual activity. Studies also show that substantial proportions of sexually experienced students have obtained contraceptives from these programs. However, given the relatively wide availability of contraceptives in most communities, most school-based clinics, especially those that did not focus on pregnancy or STD prevention, did not appear to markedly increase the school-wide use of contraceptives — that is, there appeared to be a "substitution effect," meaning that teens merely switched from getting contraception from a source outside of school to getting it in school. By contrast, two studies suggested that school-based or school-linked clinics *did* increase use of contraception when they focused much more on contraception, gave clear messages about abstinence and contraception, and provided or prescribed contraceptives.

While studies of school condom-availability programs consistently demonstrated that the programs did not increase sexual activity, they provided conflicting results about their impact upon school-wide use of condoms. These differences may reflect methodological limitations, differences in the availability of condoms in the community, or differences in the programs themselves.

Taken together, these studies suggest that family planning clinic protocols or programs, school-based and school-linked

clinics, and condom-availability programs in schools that increased condom or other contraceptive use shared common characteristics. They focused primarily (or solely) upon reproductive health and provided young people with a combination of educational materials (however modest), the opportunity for one-on-one counseling or discussions, a clear message about abstinence and condom or contraceptive use, and actual condoms or other contraceptives.

Community-Wide Initiatives with Many Components

In the past two decades, recognizing the complexity of the problem of teen pregnancy, more communities have put in place multi-component efforts to reduce rates of teen pregnancy. These initiatives typically combine such interventions as media campaigns, increased access to family planning and contraception services, sex education classes for teens, and training in parent/child communication. The research evidence on these initiatives is mixed. Each of the studies reviewed in the report measured effects on teens throughout the community, not just on those teens directly served by programs. The two most effective programs were the most intensive ones, and, in fact, when the interventions ceased, the use of condoms or pregnancy rates returned to pre-program levels, suggesting that such programs need to be maintained in order to have continuing effects. However, one of these two effective programs did not show positive results when it was tried again in a different community. The bottom line seems to be that it is very hard to change adolescent sexual or contraceptive behavior throughout an entire community. When such change is accomplished, it takes intense effort, which must be sustained.

Programs That Focus on Non-Sexual Antecedents

Programs in this category focus on broader reasons behind why teens get pregnant or cause a pregnancy, including disadvantaged families and communities, detachment from school, work, or other important social institutions, and lack of close relationships with parents and other caring adults. For instance, research suggests that teens who are doing well in school and have educa-

tional and career plans for the future are less likely to get pregnant or cause a pregnancy. Increasingly, programs to prevent teen pregnancy concentrate on helping young people develop skills and confidence, focus on education, and take advantage of job opportunities and mentoring relationships with adults — thereby helping them create reasons to make responsible decisions about sex. These efforts include service learning, vocational education and employment programs, and youth development programs, broadly defined. Early childhood programs also focus on non-sexual antecedents that may have an impact on the later sexual behavior of their participants.

Early Childhood Programs

Only one study evaluating an early childhood program met the criteria for this review. In the study of the *Abecedarian Project*, infants in low-income families were randomly assigned to a full-time, year-round day care program focused on improving intellectual and cognitive development or to regular infant day care. In elementary school, they were again randomly assigned to a three-year parent involvement program or to a normal school environment. The children were followed until age 21. The kids in the preschool program delayed childbearing by more than a year in comparison with the control group; they also performed higher on a number of intellectual and academic measures. While this is encouraging, it is only one study with a small sample, albeit with a strong scientific design.

Youth Development Programs for Adolescents

Service Learning Programs

Service learning programs include two parts: (1) voluntary service by teens in the community (e.g., tutoring, working in nursing homes, and fixing up parks and recreation areas), and (2) structured time for preparation and reflection before, during, and after service (e.g., group discussions, journal writing, and papers). Sometimes the service is part of an academic class. Service learning programs may have the strongest evidence of any intervention that they reduce actual teen pregnancy rates while the youth

are participating in the program. Among the programs with the best evidence of effectiveness are the *Teen Outreach Program* and *Reach for Health* service learning program. Although the research does not clearly indicate why service learning is so successful, several possibilities seem plausible: participants develop relationships with program facilitators, they gain a sense of autonomy and feel more competent in their relationships with peers and adults, and they feel empowered by the knowledge that they can make a difference in the lives of others. All such factors, in turn, may help increase teenagers' motivation to avoid pregnancy. In addition, participating in supervised activities — especially after school — may simply reduce the opportunities teens have to engage in risky behavior, including unprotected sex.

Vocational Education Programs

Vocational education programs provide young people with remedial, academic, and vocational education sometimes coupled with assistance in getting jobs and other health education and health services. Four studies have evaluated the effect of such programs on teen sexual risk-taking, pregnancy, and childbearing. A strong study of the *Summer Training and Education Program* (STEP) revealed that the program did not have a consistent and significant impact on either sexual activity or use of contraception. Similarly, evaluations of three programs, the *Conservation and Youth Service Corps*, the *Job Corps*, and *JOBSTART*, revealed that they did not affect overall teen pregnancy or birth rates at 15- to 48-month follow-up. Thus, these studies provide rather strong evidence that programs like these four, which offer academic and vocation education and a few support services and are quite intensive, will not decrease pregnancy or birth rates among disadvantaged teens.

Other Youth Development Programs

Two other youth development programs have been evaluated for their effect on teen pregnancy or birth rates. One of them, the *Seattle Social Development Program,* was designed to increase grade schoolers' attachment to school and family by improving teaching strategies and parenting skills. When these students were

followed to age 18, those receiving the intervention were less likely to report a pregnancy than the comparison group. This is encouraging, but the evaluation design was not strong.

Programs with Both Sexuality and Youth Development Components

Three studies have examined programs that address both reproductive health and youth development simultaneously. The first study evaluated three programs in Washington state that provided teens with small group and individualized education and skill-building sessions, as well as other individual services. Results indicated that the programs did not delay sex nor increase contraceptive use, but they did decrease the frequency of sex. The second study evaluated different programs in 44 sites in California targeted to the sisters of teen girls who had become pregnant — an interesting strategy that is based on the well-known fact that having an older sister become pregnant increases the chances that younger sister will do the same. The programs offered individual case management and group activities and services. The evaluation showed that the interventions delayed sex and decreased reported pregnancy nine months later.

Finally, a recent and very rigorous study of the comprehensive *Children's Aid Society-Carrera Program* has demonstrated that, among girls, it significantly delayed the onset of sex, increased the use of condoms and other effective methods of contraception, and reduced pregnancy and birth rates. The program did not reduce sexual risk-taking among boys. The *CAS-Carrera Program*, which is long-term, intensive, and expensive, includes many components: (1) family life and sex education, (2) individual academic assessment, tutoring, help with homework, preparation for standardized exams, and assistance with college entrance, (3) work-related activities, including a job club, stipends, individual bank accounts, employment, and career awareness, (4) self-expression through the arts, (5) sports activities, and (6) comprehensive health care, including mental health and reproductive health services and contraception. This is the first and only study to date that includes random assignment, multiple sites, and a large sample size and that found a positive

impact on sexual and contraceptive behavior, pregnancy, and births among girls for as long as three years.

What Does All This Mean?

Just as in 1997, there are still no easy answers to the problem of teen pregnancy. However, recent research suggests that there are programs in each of the three main categories described above with evidence that they reduce sexual risk-taking, pregnancy, and childbearing among teens (see "Programs with Strong Evidence of Success," on next page):

- *Programs That Focus on Sexual Antecedents:* Several sex and HIV education programs delay the onset of sex, reduce the frequency of sex, reduce the number of sexual partners among teens, or increase the use of condoms and other forms of contraception. The most successful programs share ten specific characteristics (see p. 10). In addition, several particular protocols and interventions in clinic programs also increase the use of condoms or other forms of contraception.
- *Programs That Focus on Non-Sexual Antecedents:* Certain service learning programs, which do not focus on sexual issues at all, have the strongest evidence that they actually reduce teen pregnancy rates. Other types of youth development programs, especially vocational education, have not reduced teen pregnancy or childbearing.
- *Programs That Focus on Both Sexual and Non-Sexual Antecedents:* A comprehensive, intensive, and long-term intervention, the *Children's Aid Society- Carrera Program,* which includes both youth development and reproductive health components, has been demonstrated to substantially reduce teen pregnancy and birth rates among girls over a long period of time.

These three categories of programs may seem contradictory — one focuses directly on issues of sex and contraception, one addresses non-sexual factors, and the third targets both. But finding effective programs in each category is heartening news — and conforms with what the research says about the antecedents

Programs with Strong Evidence of Success

I. Programs that Focus Primarily on Sexual Antecedents

Sex education programs covering both pregnancy and STDs/HIV[1]

- *Reducing the Risk*
- *Safer Choices*

HIV education programs[1]

- *Becoming a Responsible Teen: An HIV Risk Reduction Intervention for African-American Adolescents*
- *Making a Difference: An Abstinence Approach to STD, Teen Pregnancy, and HIV/AIDS Prevention*
- *Making a Difference: A Safer Sex Approach to STD, Teen Pregnancy, and HIV/AIDS Prevention*

II. Programs that Focus Primarily on Non-Sexual Antecedents

Service learning[2]

- *Teen Outreach Program (TOP)*
- *Reach for Health Community Youth Service Learning*

III. Programs that Focus Upon Both Sexual and Non-Sexual Antecedents

Multi-component programs with intensive sexuality and youth development component

- *Children's Aid Society-Carrera Program*[3]

1 While the sex and HIV education programs identified in this table demonstrated a positive impact upon sexual behavior and condom and contraceptive use, some other sex and HIV education programs did not have a positive effects. Studies indicated that the sex and HIV education programs in this table reduced sexual risk-taking, but they did not provide evidence they reduced teen pregnancy.

2 All the service learning programs that have been evaluated, including the *Learn and Serve* programs, have found results suggesting a positive impact upon either sexual behavior or pregnancy. The *Learn and Serve* study is not included on this list because it did not meet the criteria for being on this list, but it did confirm the efficacy of service learning. According to the analysis of TOP, the particular curriculum used in the small group component did not appear to be critical to the success of service learning.

3 This program has provided the strongest evidence for a three-year impact upon pregnancy.

of teen pregnancy and childbearing. If very different approaches prove to be effective, then communities benefit because they have more options from which to choose.

Studies of a number of other types of interventions, including community-wide initiatives and collaboratives, school-based clinics and school condom distribution programs, and some sex and HIV education programs, offer mixed results of effectiveness. In addition, the few rigorous studies of abstinence-only curricula that have been completed to date do not show any overall effect on sexual behavior or contraceptive use. That said, one should not conclude that these various interventions have no value at all or that they should necessarily be abandoned as part of the overall mix of prevention strategies. There may be a variety of such interventions whose value has not yet been identified by rigorous evaluation.

In addition, the research indicates that encouraging abstinence and urging better use of contraception are compatible goals — for at least two reasons. First, the overwhelming weight of evidence shows that sex education that discusses contraception does not increase sexual activity. Second, those programs that emphasize abstinence as the safest and best approach, while also teaching about contraceptives for sexually active youth, do not decrease contraceptive use. In fact, effective programs shared two common attributes: (1) being clearly focused on sexual behavior and contraceptive use and (2) delivering a clear message about abstaining from sex as the safest choice for teens and using protection against STDs and pregnancy if a teen is sexually active.

So, what should communities do with this information gleaned from the research literature? *Emerging Answers* suggests three strategies for employing promising approaches:

1. The best option is to replicate with fidelity (that is, carefully copy) programs that have been demonstrated to be effective with similar populations of teens.
2. The next best option is to select or design programs with the common characteristics of programs that have been effective with similar populations.

3. If a community cannot do either #1 or #2, it should use a careful, deliberate process to select or design new programs and not just rely on accustomed ways of doing things. A useful strategy is to use a process adopted by many of the people who designed the effective programs reviewed above: develop logic models. A logic model (also called a causal or program model) is a concise, causal description of exactly how certain program activities can be expected to affect particular behaviors by teens. At a minimum, a logic model requires that one be specific about what behavior one wants to change. A logic model identifies in the following order: (a) the behaviors to be changed, (b) the precursors or antecedents of these behaviors (i.e., the individual, family, social, and community factors that predispose teens to risky behaviors), and (c) the particular program activities designed to change these antecedents. This way of thinking and planning usually results in programs that have clear goals and orderly and plausible plans for reaching those goals.

In the final analysis, professionals working with youth should not adopt simplistic solutions with little chance of making a dent on the complex problem of teen pregnancy. Instead, they should be encouraged by declining rates and new research showing that some programs are making a difference. They should continue to explore many ways to address the various causes of teen pregnancy. They should replicate those programs that have the best evidence for success, build their efforts around the common elements of successful programs, and continue to explore, develop, and evaluate innovative and promising approaches.

Of course, all young people live in a larger culture that is influenced by such disparate forces as parents, peers, schools, the economy, faith institutions, and the entertainment media. So even as professionals continue to develop, implement, and evaluate better and more effective prevention programs, there is still enough work for other sectors of society to help make adolescence in America a time of education and growing up, not pregnancy and parenting.

About the Author

Douglas Kirby, Ph.D., is a Senior Research Scientist at ETR Associates in Scotts Valley, California. For more than 22 years, he has directed state-wide and nationwide studies of adolescent sexual behavior, abstinence-only programs, sexuality and HIV education programs, school-based clinics, school condom-availability programs, and youth development programs. He co-authored research on the *Reducing the Risk*, *Safer Choices*, and *Draw the Line* curricula, all of which significantly reduced unprotected sex, either by delaying sex, increasing condom use, or increasing contraceptive use. He has painted a more comprehensive and detailed picture of the risk and protective factors associated with adolescent sexual behavior, contraceptive use, and pregnancy, and has identified important common characteristics of effective sexuality education and HIV education programs. Over the years, he has also authored or co-authored more than 100 volumes, articles, and chapters on adolescent sexual behavior and programs designed to change that behavior. These have included reviews of the field for the Centers for Disease Control and Prevention, the National Institutes of Health, the former Office of Technology Assessment, and various foundations. Dr. Kirby serves on the Board of the National Campaign to Prevent Teen Pregnancy and chairs the National Campaign's Task Force on Effective Programs and Research. He is the author of *No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy* (1997).

The full, 200-page report, *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy,* is available for $15 (plus shipping and handling) from:

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Excerpts from Emerging Answers. Research Findings on Programs to Reduce Teen Pregnancy. Douglas Kirby, Ph.D. The National Campaign to Prevent Teen Pregnancy. May 2001. To include Chapter 4, "Emerging Answers: The Behavioral Impact of Programs to Reduce Adolescent Sexual Risk-Taking." The following Tables are included:

A. Table 4.1: Studies of Abstinence Programs
B. Table 4.2: Studies of Sex Education Programs
C. Table 4.3: Studies of HIV/AIDS Education Programs
D. Table 4.9: Studies of Community-Wide Pregnancy or HIV Prevention Initiatives with Multiple Components
E. Table 4.11: Studies of service Learning Programs
F. Table 4.12: Studies of Vocational Education and Employment Programs
G. Table 4.13: Studies of Other Youth Development Programs
H. Table 4.14: Studies of Multi-Component Programs with Both Sexuality and Youth Development Components

Table 4.1: Studies of Abstinence Programs

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Postponing Sexual Involvement/ENABL Kirby, Korpi, Barth, Cagampang 1995	Dispersed throughout California Varied SES N=7,753	12-13 years 7th and 8th graders M=42% F=58% Wh=38% His=31% Bl=9%	**Setting:** Classrooms in most designs; community organizations in one design. **Sessions:** 5 1-hour sessions **Content:** Designed both to help youth understand social and peer pressures to have sex and to develop and apply resistance skills; emphasis upon postponing sexual involvement; based on social influence theory. **Methods:** Taught by adults or teens.	Experimental. Random assignment of entire schools, classrooms, or individual youths. In part of the study, students were randomly assigned to adult-taught PSI, peer-taught PSI, or a control group. Matched questionnaire data were collected at baseline, 3 and 17 months post-intervention. Intervention post-test: N=3,697 Comparison post-test: N=4,056	t-tests between intervention and comparison groups using change scores.	Initiation of intercourse: 0 Frequency of sex in previous 3 months: 0 Frequency of sex in previous 12 months: 0 Number of sexual partners: 0 Use of condoms: 0 Use of birth control pills: 0 Pregnancy: Teen led: – Adult led: 0	The evaluation was very rigorous; it had random assignment, large sample sizes, long-term follow-up, and appropriate statistical analyses. It also examined the impact of PSI implemented in either community settings, individual classrooms, or entire schools.
Sex Respect, Teen-Aid, Values and Choices Weed, Olsen, DeGaston, Prigmore 1992	Utah Mixed SES N=1,963	Mean=15.5 years Middle and senior high school M=49% F=51% Wh=90% His=3% Oth=7%	**Setting:** School classrooms **Sessions:** Not reported; appear to be two to three weeks. **Content:** All three curricula focused upon abstinence (Values and Choices was edited to conform to abstinence-only and Utah guidelines). Sex Respect taught skills to avoid sex in difficult situations. It focused on self-control, self-respect, and respect for others. Teen-Aid provides information and teaches decision-making; it emphasizes that abstinence is the best choice. It provides a broader understanding of sexuality and covers dating standards. It also covers other health issues, e.g., abstinence from drugs, alcohol, and tobacco. Values and Choices provides information and promotes decision-making. It gives less emphasis to abstinence as the only correct choice.	Quasi-experimental. Three high schools and 5 junior high schools implemented the programs; 2 matched high schools and 3 matched junior high schools served as comparison groups. Matched questionnaire data were collected at baseline, 3 to 4 weeks later (at the end of each program), and one year later. Intervention group: N=1,207 Comparison group: N=756	Repeated measures analysis of covariance, controlling for variables that were related to intervention group and outcome measure. Loglinear models used for transition to sex.	Initiation of sex: **High school:** Overall: 0 Most permissive values group: + Middle permissive values group: 0 Least permissive values group: 0 High future orientation group: 0 Low future orientation group: + **Junior high school:** Overall: 0 Most permissive values group: 0 Middle permissive values group: 0 Least permissive values group: 0	The strength of this design was weakened by the lack of random assignment, failure to show baseline comparability between intervention and comparison groups, and small sample sizes for some sub-group analyses. Behavior data were based upon first cohort data only. Among youth with the most permissive values, the differences in initiation rates among the three groups were not significant. This may have been due to insufficient sample size.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.1: Studies of Abstinence Programs *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Stay SMART St. Pierre, Mark, Kaltreider, Aikin 1995	Mostly in urban areas throughout the U.S. Low SES N=273	Mean=13.6 years Not reported M=75% F=25% Wh=45% Bl=42% His=14%	**Setting:** Boys and Girls Clubs of America **Sessions:** 12 **Content:** Multi-focus: Designed to delay sex and prevent alcohol, cigarette, and marijuana use. Based on personal and social competence model of prevention (broader version of social influence theory). Included 9 sessions on life skills training (general coping skills and skills to resist negative peer influences) and 3 on postponing sexual involvement (discussed sex in media, lines to have sex, and consequences of sex and did role playing). **Methods:** A 5-session 1-year booster and a 4 5-hour 2-year booster were designed to reinforce the skills and knowledge and to help older youth be positive role models. Taught by staff members. Youth volunteered to participate.	Quasi-experimental. Fourteen clubs were assigned to 3 groups: comparison group, which received nothing; the first intervention group, which received Stay SMART without the booster; and the second intervention group, which received Stay SMART and the boosters. If youths did not participate in most of the sessions, they were dropped from the intervention groups. Matched questionnaire data were collected at baseline, 3 months later, 15 months later, and 27 months later. 3-month post-test: Stay SMART: N=83 Stay SMART + booster: N=81 Comparison: N=109	Repeated measures ANCOVA used to control for the pre-test measure of the outcome variable, gender, age, and ethnicity. There were few significant differences at baseline; none on behavior outcomes. Separate analyses for virgins and non-virgins as measured at pre-test.	**Virgins:** At 3 months: Recency of last intercourse: 0 Frequency of intercourse: 0 Combined measure: 0 At 15 months: Recency of last intercourse: 0 Frequency of intercourse: 0 Combined measure: 0 At 27 months: Recency of last intercourse: 0 Frequency of intercourse: 0, + Combined measure: 0 **Non-virgins:** At 3 months: Combined measure: 0 At 15 months: Combined measure: 0 At 27 months: Combined measure: 0	For non-virgins, results were inconsistent. Stay SMART without the booster appeared to reduce frequency of intercourse at 27 months. With the booster, it did not appear to reduce frequency. These inconsistent results, coupled with lack of random assignment, small sample sizes, very high attrition rates, and failure to adjust for clustering effect at the club level render these results inconclusive.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.2: Studies of Sex Education Programs

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Draw the Line/ Respect the Line Coyle, Kirby, Marin, Gomez, Gregorich 2000	Urban area in northern California Mixed SES N=2,829	Mean=11.5 years 6th grade M=50% F=50% His=59% Wh=17% Asn=16% Bl=5% Oth=3	**Setting:** Middle schools **Sessions:** 20 sessions: 5 in the 6th grade, 8 in the 7th grade, and 7 in the 8th grade. **Content:** Topics included consequences of unplanned sex (pregnancy, STDs, and HIV), personal sexual limit setting, and refusal skills. Based on social learning theory and social inoculation theory. Activities were highly interactive.	Experimental. Nineteen middle schools randomly assigned to intervention and control conditions. Control schools received usual STD, HIV, and pregnancy prevention education. Matched questionnaire data were collected in the spring of the 6th grade before the intervention and in the spring of the 7th and 8th grades.	Repeated measures logistic models for males and females separately, controlling for the one variable that was different between the two groups and related to initiation of sex.	**Initiation of intercourse:** At end of 7th grade: Boys: + Girls: 0 At end of 8th grade: Boys: + Girls: 0 **Had sex in last 12 months:** At end of 7th grade: Boys: + Girls: 0 At end of 8th grade: Boys: + Girls: 0	In general, this was a very rigorous study with random assignment of schools, large sample sizes, long-term measurement of behavior, and proper statistical analysis. However, the significance of the impact upon sex in the last 12 months depended upon the type of statistical analysis used.
Health for Life Project Moberg, Piper 1998	Wisconsin Mixed and middle SES N=1,981	6th grade M=48% F=52% W=96% Oth=4%	**Setting:** Middle schools **Sessions:** 58 total: 16 on sexuality **Content:** Comprehensive health curriculum designed to positively affect alcohol use, tobacco use, marijuana use, nutrition, and sexual behavior. Based on social influences model and principles of adolescent development. Skill-based. Peer, parent, and community components. Topics: understanding social situations, refusal skills, parental values, media, communication with parents and the opposite sex, responsibility for health behaviors, risks of sexual activity, sexuality facts, and birth control information.	Experimental. Twenty-one middle schools randomly assigned to intervention and control conditions, stratifying for substance use. Schools assigned to intervention condition could choose between an age-appropriate version taught in grades 6-8, or intensive version taught in grade 7. Control schools received other prevention-oriented curricula. Matched questionnaire data were collected in the fall of the 6th, 7th, 8th, 9th, and 10th grades.	Logistic regression was used to control for baseline measures of substance use, non-intercourse involvement with opposite sex and to mimic an ANCOVA design. Adjustments for clustering.	**Initiation of intercourse:** At grade 8: 0 At grade 9: – At grade 10: – **Sex last month:** At grade 8: – At grade 9: 0 At grade 10: – **Consistent condom use:** At grade 8: 0 At grade 9: 0 At grade 10: 0	In general, this was a very rigorous study with random assignment of schools, large sample sizes, long-term measurement of behavior, and proper statistical analysis. However, it was not possible to measure whether students had ever had sex at baseline.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.2: Studies of Sex Education Programs *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
McMaster Teen Program Thomas, Mitchell, Devlin, Goldsmith, Singer, Watters 1992 Mitchel-DiCenso, Thomas, Devlin, Goldsmith, Willan, Singer, Marks, Watters, Hewson 1997	Ontario, Canada Not reported N=2,570	Mean=12.7 years 7th and 8th graders M=48% F=52% Not reported English as primary language=75%	**Setting:** Health classes in junior high schools. Students were divided into small groups of 6-8 students each. **Sessions:** 10 **Content:** Adolescent development, peer pressure, gender roles, responsibility in relationships, stages of intimacy, adolescent pregnancy and childbearing, and decision-making. **Methods:** Tutors used group discussion, question-and-answer periods, films, and role-plays.	Experimental. Twenty-one schools randomly assigned to treatment and control conditions. Ten control schools received the conventional sex education curriculum. Matched questionnaire data were collected at baseline, 3-month post-intervention, and 4 follow-up periods at 1-year intervals. Intervention post-test: N=1,593 Comparison post-test: N= 977	Logistic regression was used to control for school, school size, gender, and any other variables related to the outcome variables. Treatment group was added last to test its effect. Both overall and separate analyses by gender.	**Initiation of intercourse:** At 3 months: 0 At 1 year: 0 At 4 years: 0 **Contraceptive use:** Consistent use At 3 months: 0 At 1 year: 0 Males: + Female: 0 At 4 years: 0 **Pregnancy rates:** At 3 months: 0 At 1 year: 0 At 4 years: 0	The content of the treatment intervention did not appear much stronger than that of the control intervention. The evaluation was rigorous; it had random assignment of schools, large sample sizes, short- and long-term follow-up, low dropout rates, and appropriate statistical analyses. However, despite the random assignment of schools, males in the intervention group at baseline were more likely to have initiated intercourse than males in the control group at baseline.
Postponing Sexual Involvement (PSI) and Human Sexuality Howard, McCabe 1990	Atlanta, GA Low SES N=536	13-14 years 8th graders M=34% F=66% BI=99%	**Setting:** Regular classrooms **Sessions:** 10 PSI=5 hr. Human Sexuality=5 hr. **Content:** PSI: Designed both to help youth understand social and peer pressures to have sex and to develop and apply resistance skills; emphasis upon postponing sexual involvement; based on social influence theory. Human Sexuality: 5 basic sessions on human sexuality, decision-making, and contraceptives. **Methods:** Taught by peer leaders (11th and 12th graders).	Quasi-experimental. Intervention: one school district received PSI and Human Sexuality. Comparison: 3 smaller school districts received existing programs. Telephone interviews were conducted in the 8th, 9th, and 12th grades. Sample = children of parents who were patients at a public hospital. Matched questionnaire data were collected at baseline and post-intervention. Intervention post-test: N=395 Comparison post-test: N=141	t-tests between intervention and comparison groups at pre- and post-test. Initial equivalence of intervention / comparison established with t-tests.	**Initiation of intercourse:** End 8th grade: + End 9th grade: + End 12th grade: 0 **Frequency of intercourse:** Inexperienced at pre-test but initiating by follow-up: End 9th grade: + End 12th grade: 0 Experienced at pre-test: 0 **Contraceptive use:** Inexperienced at pre-test but initiating by follow-up: End 9th grade: + End 12th grade: 0 Experienced at pre-test: End 9th grade: 0 End 12th grade: 0	A limitation of the study was the fact that intervention and comparison groups lived in different geographic areas. Some background characteristics were controlled through sampling procedures to reduce the impact of this difference. Other events or activities that might have affected either the intervention group or comparison group differently were not controlled.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.2: Studies of Sex Education Programs *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Postponing Sexual Involvement (PSI) and Human Sexuality (Adapted) Little, Rankin 2001	Cortland, NY Not reported N=271	Mean=14.0 years 8th graders Not reported Wh=88% Oth=12%	**Setting:** Regular classrooms **Sessions:** 4 **Content:** PSI: Designed both to help youth understand social and peer pressures to have sex and to develop and apply resistance skills; emphasis upon postponing sexual involvement; based on social influence theory. Included media analysis and substance abuse information. **Methods:** Taught by peer leaders (10th graders).	Quasi-experimental. Intervention: 1 school received PSI. Comparison: 3 smaller schools received existing programs, but not PSI or other peer programs. Unmatched questionnaire data were collected at baseline, 2 months, and 6 months. Intervention 6-month: N=166 Comparison 6-month: N=105	t-tests between intervention and comparison groups at pre- and post-tests. Initial equivalence of intervention/ comparison established with t-tests.	Ever had consenting sex: 0 Frequency of intercourse in the last month: 0 Frequency of intercourse in the last 12 months: 0 Number of sexual partners: 0	This was not a strong evaluation design. Pre- and post-questionnaires were not matched and there was greater attrition among the intervention group. Modest sample sizes might have obscured program impact, but no behavioral results were close to significance.
Postponing Sexual Involvement (PSI), Human Sexuality, and Health Screening Aarons, Jenkins, Raine, El-Khorazaty, Woodward, Williams, Clar, Wingrove 2000	Washington, DC Low SES N=2,099	Mean=12.8 years 7th graders M=48% F=52% Bl=83% His=13% Oth=2%	**Setting:** Schools. **Content:** Human sexuality: 3 sessions on reproductive health taught by health professionals. PSI: 5 sessions taught by 10th and 11th graders. Designed both to help youth understand social and peer pressures to have sex and to develop and apply resistance skills; emphasis upon postponing sexual involvement; based on social influence theory. Included media analysis and substance abuse information. Health screening and individual assessment: Students completed a health risk assessment. Individual interviews were conducted with youth with problems or risk behaviors. Small group sessions: 8 sessions on different health topics. Other school-wide activities.	Experimental. Six schools were paired and the then randomly assigned to intervention and control conditions. Unmatched questionnaire data were collected during the middle of the 7th grade (baseline), the end of the 7th grade, the beginning of the 8th grade, and the end of the 8th grade. Baseline 7th grade survey: N=522 Final 8th grade followup: N=422	Logistic regression controlling for differences between the 2 groups of schools, and conducted separately for each gender.	**Initiation of sex:** Girls: End of 7th: + Beginning of 8th: 0 End of 8th: + Boys: End of 7th: 0 Beginning of 8th: 0 End of 8th: 0 **Contraceptive use at last sex:** Girls: End of 7th: + Beginning of 8th: + End of 8th: + Boys: End of 7th: 0 Beginning of 8th: 0 End of 8th: 0	Although 6 schools were randomized, the strength of this design was substantially weakened by the failure to collect matched pre-post questionnaire data, the closing and relocation of one school, changes in ethnic composition of schools, the failure to adjust for clustering in schools, and apparently the failure to control for baseline differences in the outcome behavior.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.2: Studies of Sex Education Programs *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Project IMPACT Liebermann, Gray, Wier, Fiorentino, Maloney 2000	New York, NY Low SES N=312	Mean=12.9 years 7th and 8th graders M=33% F=67% Bl=66% His=22% Oth=11%	**Setting:** 3 middle schools. **Sessions:** 12 to 14 class sessions over one semester. **Content:** Topics include anatomy, pressure to have sex, coping with peer pressure and media pressure, risks of sexual involvement, STDs, and HIV/AIDS. Abstinence is emphasized, but contraception is discussed. Students volunteer and participate in small groups of 8 to 12 members.	Quasi-experimental. Intervention and comparison students were recruited from different areas of the same schools Matched questionnaire data were collected at baseline, 3 to 4 months later, and 14 to 18 months later. Intervention 14-18 month: N=124 Comparison 14-18 month: N=186	t-tests to measure difference in change scores and chi-square tests for dichotomous variables.	Initiation of sex: 0 Condom use at last sex: 0 Pregnancy: 0	Differences between intervention groups at baseline might not have been well-controlled. There was low retention (59%). Modest sample sizes might have obscured program impact, but only one behavioral result was close to significance.
Project Model Health Moberg, Piper 1990	Near Madison, WI Middle SES N=197	Not reported 8th graders M=45% F=55% Wh=100%	**Setting:** Teacher/advisor periods in middle schools. **Sessions:** 64 half-hour classes. **Content:** Comprehensive health curriculum including nutrition, marijuana use, tobacco use, drinking and driving, and sexuality. Based upon social learning theory and social influence theory. Included discussions of the media, information on peer behaviors and norms, emphasis upon short-term effects, public commitments to change behavior, and school and community advocacy for healthy behaviors. **Methods:** Trained and used college instructors, 2 per class. Used role-playing practice.	Quasi-experimental. Eighth graders in 2 schools were assigned to intervention and comparison groups. Comparison group received standard health curriculum. Matched questionnaire data were collected just before the intervention, the following spring, and the spring of the year later. Also, during the follow-up period, data were collected from the preceding cohort of 8th graders in the intervention school. Intervention post-test: N=115 Comparison post-test: N=82	Two-way (treatment group by testing occasion) repeated measures analysis of variance and covariance multiple regression controlling for ever had sex at pre-test.	Had sex last month: 0	This was a weak design: individual students were not randomly assigned to conditions; the schools were somewhat distant from one another; the sample sizes were small; there were large pre-test differences in ever had sex at pre-test (5.4% vs. 13.6%); there was considerable attrition; and the results varied with the type of statistical analysis employed. Some analyses indicated that the program delayed the onset of intercourse.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.2: Studies of Sex Education Programs *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Project SNAPP Kirby, Korpi, Adivi, Weissman 1997	Los Angeles, CA Low SES N=1,657	Mean=12.3 years 7th graders M=46% F=54% His=64% Asn=13% Bl=9% Wh=5%	**Setting:** Health or sex education classes in schools **Sessions:** 8 **Content:** Based upon social learning theory; covered basic facts, risks, and consequences of sex, pressures to have sex, decision-making, assertiveness skills, condoms and contraception, and community resources. **Methods:** Interactive activities: games, role plays, large- and small-group activities, guided discussion. Taught by well-trained peer educators, including HIV+ males and teen mothers.	Experimental. 102 classrooms of students were randomly assigned to treatment group, which received regular instruction plus SNAPP, and control group, which received regular instruction. Matched questionnaire data were collected at baseline, 5 months, and 17 months. Intervention post-test: N=772 Control post-test: N=757	z-tests between intervention and comparison groups using change scores. Both overall and separate analyses by gender.	Initiation of sex: 0 Frequency of sex: 0 Number of sexual partners: 0 Use of condoms at last sex: 0 Use of birth control pills at last sex: 0 Pregnancy rates: 0 STD rates: 0	There were few changes in the mediating variables that might affect behavior. This was a rigorous design with random assignment, large sample sizes, long-term measurement, and measurement of behavior.
Reducing the Risk Hubbard, Geise, Rainey 1998	Urban and rural areas in Arkansas Varied SES N=212	Not reported 9th=8% 10th=49% 11th=31% 12th=12% M=48% F=52% Wh=85% Bl=14% Othr=1%	**Setting:** Health education classes. **Sessions:** 16 **Content:** Cognitive behavioral theory; social inoculation theory; strong emphasis on avoiding unprotected sex either by avoiding sex or using protection. **Methods:** Experiential; many role-plays to build skills and self-efficacy.	Quasi-experimental. Five intervention school districts were matched with 5 comparison districts. Comparison group received existing sex education activities from state-approved texts or abstinence-only curricula. Matched questionnaire data were collected at baseline and 18-months later from one class selected from each school. Intervention post-test: N=106 Comparison post-test: N=106	One-way z-tests between intervention and comparison groups at 18 months. Initial equivalence of intervention and comparison groups determined.	Initiation of sex: + Condom Use: Sexually inexperienced at pre-test: +	There were no significant differences between groups at baseline, but there was no random assignment. Attrition was very high (58%), in part because of graduation from high school. Sub-group sample sizes were small.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.2: Studies of Sex Education Programs *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Reducing the Risk Kirby, Barth, Leland, Fetro 1991	Urban and rural areas throughout California Varied SES N=758	Not reported 9th=27% 10th=56% 11th=9% 12th=6% M=47% F=53% Wh=62% His=20% Asn=9% AmInd=2% Bl=2% Othr=5%	**Setting:** Health education classes. **Sessions:** 15 **Content:** Cognitive behavioral theory, social inoculation theory; strong emphasis on avoiding unprotected sex either by avoiding sex or using protection. **Methods:** Experiential; many role-plays to build skills and self-efficacy.	Quasi-experimental. Partial random assignment of classrooms to intervention or comparison groups. Comparison group received existing sex education programs of equal length. Matched questionnaire data were collected at baseline, 6-months, and 18-months post-intervention. Intervention post-test: N=429 Comparison post-test: N=329	Chi-square or t-tests between intervention and comparison groups at 6 and 18 months. Initial equivalence of intervention/ comparison established with t- or chi-square tests.	**Initiation of intercourse:** At 6 months: 0 At 18 months: + **Frequency of intercourse: 0** **Contraceptive use at first sex:** At 6 months: 0 At 18 months: 0 **Contraceptive use at last sex:** At 6 months: 0 At 18 months: 0 **Frequency of contraceptive use at 18 months:** Overall: 0 Females: + Males: 0 Lower-risk youth: + Higher-risk youth: 0 **Unprotected intercourse at 18 months:** Overall: 0 Sexually inexperienced at pre-test: + Sexually experienced at pre-test: 0 **Teen pregnancy rates: 0**	Sample sizes for some subgroups were too small for reasonable power.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.2: Studies of Sex Education Programs *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Safer Choices Coyle, Basen-Engquist, Kirby, Parcel, Banspach, Collins, Baumler, Carvajal, Harrist Forthcoming (June 2001)	Urban and suburban areas in San Jose, CA and Houston, TX Varied SES Cohort N=3,058	9th graders M=48% F=52% Wh=30% His=27% Bl=17% As=18% Oth=7%	**Setting:** High schools. **Sessions:** 10 in 9th grade and 10 in 10th grade. **Content:** Five major components: school health protection council, curriculum, peer resources and school environment, parent education, and school-community linkages. Based on social cognitive theory, social influence theory, and models of school change. Emphasized abstinence as the safest choice; condoms as safer than unprotected sex. Curriculum topics focused on knowledge, norms and skills to avoid sex or use condoms. Skill-based and interactive.	Experimental. Twenty schools were randomly assigned to treatment and control conditions. Control schools received existing sex/HIV education programs that were mostly knowledge-based. Matched questionnaire data were collected fall of 9th grade (baseline) and spring of 9th, 10th, and 11th grades.	Linear, logistic, and negative binomical regression models in a repeated measures ANCOVA framework to adjust for baseline variables. Impact was measured over the 31-month period. All were multilevel to adjust for clustering	Initiation of intercourse: 0 Frequency of sex: 0 Number of sex partners: 0 Use of condoms at last sex: + Use of contraception at last sex: + Frequency of sex without condoms: + Number of sexual partners without condoms: +	This was a very strong design with random assignment, large sample sizes, long-term measurement of behavior, and proper statistical analysis in two different locations.
Skills for Healthy Relationships Warren, King 1994	Canada Not reported N=2,323	14-15 years 9th graders Not reported Not reported	**Setting:** 9th grade classes. **Sessions:** 20 1-hour classes. **Content:** Based, in part, upon theory of reasoned action. Focused upon improving knowledge, attitudes, motivation, and skills. Designed to maintain abstinence, produce a return to abstinence, and increase protective measures (e.g., condom use). Skills included interpersonal skills (assertiveness) and condom skills (purchasing and putting on a condom). **Methods:** Taught by teachers with use of peer-led, small group discussions.	Quasi-experimental. In each of 4 provinces, 2 school boards were matched and assigned to intervention and comparison groups. Fifty-eight schools were assigned to receive the intervention program or the normal HIV/AIDS/STD education program. Matched questionnaire data in 123 classes were collected before and after the 9th grade curriculum, the beginning of the 10th grade, and the beginning of the 11th grade. Intervention post-test: N=1,358 Comparison post-test: N=965	t-tests between intervention and comparison groups at each of four time intervals. t-tests between pre-test data and post-test data for each group. Regression analyses.	Initiation of intercourse: 0 Always used a condom during last two months: 0 Use of a condom during last act of intercourse: 0	The strength of this design was increased by the large number of classrooms and students participating, the long-term follow-up, the similarity of intervention and comparison groups students at pre-test, and the analysis of change scores over time.

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Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.2: Studies of Sex Education Programs *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Taking Care of Business Nicholson, Postrado 1991	Dallas, Texas; Memphis, Tennessee; Omaha, Nebraska; Wilmington, Delaware Low SES Baseline: N=343	14-20 years Not reported F=100% Bl=85% Wh=9%	**Setting:** Girls Clubs. **Sessions:** 9 2-hour classes. **Content:** Focused upon the futures of women, career planning, goal setting, decision-making, assertiveness, postponing sex, and contraception. **Methods:** Interactive exercises, role-playing.	Quasi-experimental. Girls and parents who volunteered to participate in programs within the 4 Girls Clubs constituted the program group, while those who chose not to participate constituted the comparison group. Questionnaire data were collected at baseline and annually for 2 years.	Multiple-logistic analysis, controlling for background and baseline characteristics. There were significant differences at baseline between the treatment and comparison groups.	Initiate intercourse: 0 Engage in intercourse without birth control: 0 Pregnancy: 0	The strength of this design was reduced by the lack of random assignment, relatively small sample sizes, and results that varied with how girls who participated in only a few sessions were treated. There were positive findings for these girls who completed most sessions.
Teen Talk Eisen, Zellman, McAlister 1990	Texas and California Not reported N=888	13-14=32% 15-17=65% 18-19=3% Not reported M=46% F=54% His=51% Bl=22% Wh=17% Othr=10%	**Setting:** 6 family planning service agencies; 2 programs in one school district. **Sessions:** 8 12-hour classes. **Content:** Theory-based (health belief model, social learning theory). Factual material, values, feelings, decision-making, skill-building. **Methods:** Lectures and discussion, role-playing, films.	Experimental. Random assignment of classes. Comparison classes received varied programs of equal duration to intervention. Matched questionnaire data were collected at baseline, immediate post-intervention, and 1-year follow-up. Intervention post-test: N=462 Comparison post-test: N=426	Logistic regression controlling for background characteristics. Separate analyses for gender/sexually (in)experienced. Males: N=197 Females: N=290 Inexperienced at pre-test but initiating by follow-up: Males: N=79 Females: N=67 Experienced at pre-test: Males: N=115 Females: N=92	**Initiation of intercourse:** Overall: 0 Males: + Females: 0 **Contraceptive use:** Inexperienced at pre-test but initiating by follow-up: Males: First intercourse: 0 Last intercourse: 0 Consistent use: 0 Females: First intercourse: – Last intercourse: 0 Consistent use: – Experienced at pre-test: Males: Last intercourse: 0 Consistent use: + Females: Last intercourse: 0 Consistent use: 0	The combination of varied sex education programs among the comparison groups, small sample sizes for many analyses, and inconsistent results make it difficult to draw conclusions from these results.

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Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.2: Studies of Sex Education Programs *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Untitled Blake, Ledsky, Lohrmann, Bechhofer, Nichols, Windsor, Banspach, Jones Unpublished (2000)	Michigan communities Not reported N=30 teachers and 3,516 students	14=19% 15=51% 16=29% 9th=63% 10th=37% M=56% F=44% Wh=52% Bl=36% His=3% Oth=9%	**Setting:** School classrooms **Sessions:** 17 **Content:** Based on key characteristics of effective programs and social learning theory. Interactive and skills-based. Emphasized abstinence, but briefly covered condoms.	Experimental. Thirty teachers were matched and then randomly assigned to implement either the intervention curriculum or a comparison curriculum to 69 classrooms. Unmatched questionnaire data were collected at baseline, immediate post-test, and six-month follow-up. Intervention follow-up: N=564 Comparison follow-up: N=785	Logistic regression and ANCOVA controlling for baseline differences and gender.	Initiation of sex: 0 Had sex in past 3 months: 0	The strength of this design was reduced by the failure to collect matched questionnaire data. The statistical power to detect changes in initiation of sex was reduced by using the teacher as the unit of analysis and short-term follow-up. Six-month follow-up was not high (64%).
Untitled (Three sexuality education programs) Kirby 1985	Dispersed throughout the U.S. Varied SES N's for individual programs ranged from 301 to 556.	Not reported 9-12 graders Varied gender proportions All major ethnic groups represented	**Setting:** Health or sex education classes. **Sessions:** 6 hours to 1 full semester. **Content:** Varied with the program; some were mostly knowledge-based; a few used role playing to teach communication skills.	Quasi-experimental. Matched questionnaire data were collected at baseline and post-intervention in 2 sites. In the third site, follow-up data were collected at 3 months.	t-tests between intervention and comparison groups using change scores.	Initiation of intercourse 3 programs: 0 Frequency of sex in the previous month 3 programs: 0 Use of contraceptives: 3 programs: 0 Pregnancy: 1 program: 0	This was a study of 15 different sexuality education programs in the U.S. Three of the studies met the criteria for this review. Those three are summarized in this table. These were not a strong set of studies. Students were not randomly assigned; sample sizes for individual programs were often too small for reasonable power; and longer term effects were not measured for 2 of the 3 programs.

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Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.2: Studies of Sex Education Programs *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Untitled (Natural family planning) Klaus, Bryan, Bryant, Fagan, Harrigan, Kearns 1987	Seven areas in the U.S. Low-middle SES N=304	15- to 17-year-olds Not reported F=100% Unk=34% Wh=38% Bl=20% His=8% Oth=1%	**Setting:** Schools. **Sessions:** Every 2 weeks for first 3 months, once a month for 3 months, every 3 months for 6 months. **Content:** Focused on proper use of the Billings method of natural family planning. Also other contraceptive methods, relationships, vocational future, ethical and religious positions. Individual review of each girl's chart.	Quasi-experimental. Girls agreeing to use the Billings method were compared with girls from the general population and from two family planning clinics. Matched questionnaire data were collected at baseline and 12 months. Intervention post-test=242 Comparison post-test=62	Not reported.	Initiation of intercourse: +	This was a very weak evaluation design with very strong self-selection effects into the program.
Wise Guys Gottsegen, Philliber Unpublished (2000)	Greensboro, NC High-risk youth N=335	12 or 13=74% 7th=76% M=100% Wh=63% Oth=37%	**Setting:** Schools. **Sessions:** 8 class sessions, 1 per week. **Content:** Provides information about reproduction, contraception and STDs; seeks to develop healthy values about sexuality, responsibility, respect for women, resistance skills, and communication skills. **Methods:** A variety of active learning methods, including role playing.	Quasi-experimental. Principals identified males at risk of early sexual involvement in both the intervention and comparison schools. Unmatched questionnaire data collected at baseline, 8 weeks later, and 6 months later. Baseline intervention: N=94 Baseline comparison: N=55	Not reported.	Initiation of sex: 0 Contraceptive use at last sex: + Frequency of contraceptive use: +	This study had a very weak design. The two groups did not appear very similar at baseline, baseline and follow-up questionnaire data were not matched, sample sizes were small, and the statistical analysis was weak (only significant results were presented in the tables and results did not appear to control for differences between the two groups).

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Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.3: Studies of HIV/AIDS Education Programs

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date(s)	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
AIDS Prevention for Adolescents in School Walter, Vaughan 1993	New York, NY Low SES N=867	Not reported 9th and 11th graders M=42% F=58% Bl=37% Hls=35% Wh=13% Asn=11% Othr=4%	**Setting:** General education classes. **Sessions:** 6 **Content:** Health belief model, social cognitive theory, model of social influence; focus upon correcting facts about AIDS, teaching cognitive skills to appraise risk of transmission, increasing knowledge of AIDS-prevention resources, changing perceptions of frequency of peer risk-taking behaviors, clarifying personal values, understanding external influences, and teaching skills to delay intercourse and/or consistently use condoms.	Quasi-experimental. Four high schools were divided into two matched pairs. Within each pair, one school provided 9th grade program classes and 11th grade comparison classes, while the other school provided 9th grade comparison classes and 11th grade program classes. Comparison classes received no AIDS prevention program. Matched questionnaire data were collected at baseline and 3-month post-intervention. Intervention post-test: N=477 Comparison post-test: N=390	t-tests between intervention and comparison groups using change scores. Multiple regression was used to control for background characteristics and baseline scores.	Abstinence: 0 Intercourse with high-risk partner: + Monogamous relationships: + Consistent condom use: +	The 3-month post-test did not allow measurement of long-term effects. Changes in behavior were modest.
Becoming A Responsible Teen St. Lawrence, Brasfield Jefferson, Alleyne, O'Bannon, Shirley 1995	Jackson, MS Low SES N=225	Mean=15.3 years Mean grade=9.7 M=28% F=72% Bl=100%	**Setting:** Conference room in a health center. **Sessions:** 8 90- to 120-minute weekly meetings. **Content:** Based upon social learning theory. Designed to affect cognitive and emotional meanings attached to risky behavior, model behavioral competencies, and provide practice, feedback, and reinforce new skills. Covered AIDS information, sexual decisions and pressures, use of condoms, "lines," effective social skills, and situations that would be difficult to handle. **Methods:** Small group discussions with 5-15 youths were led by male and female co-facilitators. Considerable role-playing and practice. Sessions with HIV+ youth.	Experimental. Individual youth were randomly assigned to receive the study intervention or an alternative 2-hour educational intervention. Matched questionnaire data were collected at baseline, 2 months later, 6 months later, and 12 months later.	Repeated measures MANOVA used to measure impact of group and gender. No significant differences at pre-test.	Initiation of intercourse: + Sexual intercourse during previous two months: + Number of sex partners: + Frequency of unprotected vaginal intercourse: Males: + Females: 0 Frequency of condom-protected vaginal intercourse: + Frequency of unprotected oral sex: + Frequency of unprotected anal sex: + Frequency of condom-protected anal sex: 0 Percent of acts of intercourse protected by condoms: +	This was a very strong evaluation design with random assignment, long-term follow-up, multiple outcome measures, and sophisticated statistical analysis. On some outcomes, reported risks fluctuated considerably from one time period to another.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.3: Studies of HIV/AIDS Education Programs *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Be Proud, Be Responsible Jemmott III, Jemmott, Fong 1992	Philadelphia, PA Low SES N=150	Mean=14.6 years Not reported M=100% Bl=100%	**Setting:** At a school on a Saturday. **Sessions:** 5 continuous hours. **Content:** Based upon theory of reasoned action. Included information about risks, videotapes, games, exercises, role-playing, and other active learning activities. All were culturally and developmentally appropriate. **Methods:** Implemented by 27 black facilitators with backgrounds in human sexuality. Taught in small groups with a mean of about 6 youths.	Experimental. Youths were randomly assigned to the treatment group and a control group, which received a career, opportunities intervention. Matched questionnaire data were collected at baseline, at the end of the interventions, and 3 months later.	Analysis of covariance was used to control for the gender of the facilitator and the respective pre-intervention measure of the outcome being measured.	Had sex: 0 Number of days had sex: + Number of partners: + Rated frequency of condom use: + Number of days of sex without condoms: + Had heterosexual anal sex: + Number of days had heterosexual anal sex: 0 Number of female anal sex partners: 0	In general, this was a strong evaluation design. However, the sample size was relatively small, and the 3-month post-test did not allow measurement of long-term effects.

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Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.3: Studies of HIV/AIDS Education Programs *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Be Proud! Be Responsible! A Sexual Abstinence Curriculum **Be Proud! Be Responsible! A Safer Sex Curriculum** ("Be Proud! Be Responsible!" now known as "Making a Difference") Jemmott, Jemmott, Fong 1998	Philadelphia, PA Low income Total N=659	Mean=11.8 years 6-7th graders M=47% F=53% Bl=100%	**Setting:** Recruited from schools for a Saturday program on school campuses. **Sessions:** 8 1-hour modules delivered over two Saturdays. **Content:** 2 curricula, 1 abstinence-based, 1 safer sex-based. Based on cognitive-behavior theories and elicitation research. Small group discussions, videos, games, brainstorming, experiential exercises, and skill-building exercises. The safer sex curriculum also addressed hedonistic beliefs about condom use. Trained adult or peer facilitators.	Experimental. Random assignment to 2 treatment groups and 1 control group that received different intervention. Matched questionnaire data were collected at baseline, 3 months, 6 months, and 12 months.	Chi-squared tests or t-tests.	**Abstinence-based:** Initiation of intercourse: At 3 months: + Frequency of sex: At 3 months: 0 At 6 months: 0 At 12 months: 0 Condom use: At 3 months: 0 At 6 months: 0 At 12 months: + Frequency of unprotected sex: At 3 months: 0 At 6 months: 0 At 12 months: 0 **Safer sex-based:** Initiation of intercourse: At 3 months: 0 Frequency of sex: At 3 months: 0 At 6 months: + At 12 months: + Condom use: At 3 months: + At 6 months: + At 12 months: + Frequency of unprotected sex: At 3 months: + At 6 months: + At 12 months: 0	This was a very strong study. Both the design was strong and the results were positive. Effects in mediating variables supported behavioral effects. Non-significant behavioral effects were typically in the desired direction. The safer sex curriculum had significant effects upon frequency of unprotected sex among youths sexually experienced at baseline, but not all youth. Results did not differ by matching participants and staff on gender, nor by adult versus peer facilitators.

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Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.3: Studies of HIV/AIDS Education Programs *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Get Real About AIDS Main, Iverson, McGloin, Banspach, Collins, Rugg, Kolbe 1994	Colorado Not reported N=979	Mean=15 years 9th=60% 10th=13% 11th=22% 12th=5% M=51% F=49% Wh=65% His=21% Bl=6% Asn=3% Othr=5%	**Setting:** Classrooms. **Sessions:** 15. **Content:** Based upon social cognitive theory and theory of reasoned action. Emphasized skills. Topics covered: functional knowledge about HIV-risk avoidance, impact of norms, condom use, and skills to identify, manage, avoid, and leave risky situations. Teachers received 40 hours of training. Posters were distributed throughout the school and students were given HIV information cards. **Methods:** 25 teachers taught curriculum.	Quasi-experimental. Seventeen schools were assigned to the intervention group and the comparison group, which received the school's usual HIV education program. Four of the 6 comparison schools offered no program. Matched questionnaire data were collected at baseline, 2 months after the intervention, and 6 months after the intervention. Intervention post-test: N=560 Comparison post-test: N=419	Random-effects logistic and linear regression models were used to analyze student-level data, controlling for clustering of students within schools. Analyses controlled for student pre-test response (outcome variable measured at baseline), grade, ethnicity, and gender.	Ever had sex: 0 Ever purchased condoms: + Number of sexual encounters during last 2 months: 0 Number of sexual partners during last 2 months: + Condom use during last 2 months: +	The students were followed for a relatively short period of time. Given the quasi-experimental design, sophisticated and proper analytic methods were used that corrected for the clustering effect of students. There were difficulties in matching pre-test and post-test scores for students. All the results were just barely significant at the .05 level.
Healthy Oakland Teens Ekstrand, Siegel, Nido, Faigeles, Cummings, Battle, Krasnovsky, Chiment, Coates 1996	Oakland, CA Low SES N=250	12-16 years Mean=13.1 years 7th graders M=48% F=52% Bl=78% His=11% Wh=7% Othr=5%	**Setting:** Social science classes at a middle school. **Sessions:** 5 adult-led / 8 peer-led. **Content:** 5 adult-led sessions included basic information on anatomy, substance abuse, HIV/STDs, and preventive behaviors. Eight peer-led sessions were more interactive and included perception of risk, values clarification, costs and benefits of preventive behaviors, influence of alcohol and drugs, peer norms, refusal skills, and condom use.	Quasi-experimental. A cohort of students in the intervention school were compared with cohorts of students in similar nearby schools. Baseline questionnaire data were collected in the 7th grade and 8-11 months later in the 8th grade. Intervention post-test: N=107 Control post-test: N=143	The 2 groups were compared with logistic regression controlling for baseline differences.	Initiation of sex: +	The validity of these results was reduced by the lack of random assignment, some differences between the intervention and comparison groups, relatively small sample size for analyses of initiation of sex (N=190), and failure to adjust for clustering effects. In addition, parent consent requirements changed, but the study was restricted to those respondents who completed surveys when passive parental consent was still in effect.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.3: Studies of HIV/AIDS Education Programs *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Untitled Gillmore, Morrison, Richey, Balassone, Gutierrrez, Farris 1997	Seattle, WA Not reported N=314	14-19 years Mean=9th grade M=54% F=46% Bl=52% Wh=48%	**Setting:** Juvenile detention, public health STD clinics, and other clinics. **Content:** Group 1 received a comic book with basic information and examples of communication skills. Group 2 received the comic book and a videotape with teen actors modeling skills for negotiating condom use. Group 3 participated in 2 4-hour skill-training sessions with role playing, small group exercises, games, and both the comic book and the videotape.	Experimental. Youth were randomly assigned to 3 groups. Matched questionnaire data were collected at baseline, 3 months later, and 6 months later.	Repeated measures analysis of covariance was used to control for baseline differences.	Number of sexual partners: 0 Condom use: 0 Refusing sex without condom: 0	In addition to the lack of behavioral impact, there were few significant changes in mediating variables. In general this was a strong research design, but the validity of the results were limited by the small sample sizes for some analyses.
Untitled Magura, Kang, Shapiro 1994	New York, NY Not reported N=157	Mean=17.8 years Not reported M=100% Bl=65% His=33% Wh=2%	**Setting:** Department of Correction's adolescent reception and detention center. **Sessions:** 4 1-hour sessions. **Content:** Based upon techniques of problem-solving therapy. Included small-group discussions focusing upon health issues, especially AIDS and drug abuse. Also included decision-making about drugs, sex, and HIV and role-playing. Participants volunteered for program.	Quasi-experimental. Intervention group received the program; the comparison group members were wait-listed but were released before receiving the program. Matched interview data were collected at baseline and 10 months later (5 months after release from jail). Intervention post-test: N=58 Comparison post-test: N=99	Multiple regression or multiple logistic regression were used to measure impact of the intervention and to control for the baseline measure of the outcome variable. No significant difference on background characteristics, including behaviors at pre-test. One-tailed tests of significance used.	Multiple sexual partners: 0 High-risk sexual partners: 0 Anal sex: 0 Condom use during vaginal sex: + Condom use during oral/anal sex: + Condom use in general: +	The lack of random assignment and relatively small sample size reduced the strength of the study design. However, the veracity of the findings on condom use are increased by the similarity of the intervention and comparison groups, the controlling for pre-test measures, and the combination of consistent findings on condom use and lack of findings for other risk-taking behaviors (e.g., drug use).

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.3: Studies of HIV/AIDS Education Programs *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Untitled Rotheram-Borus, Koopman, Haignere, Davies 1991	New York, NY Low SES (runaway youths) N=145	11-18 years Mean=15.5 years Not reported M=36% F=64% Bl=63% His=22% Wh=8% Othr=7%	**Setting:** Shelter for runaway youth **Sessions:** Designed as 20, but was 3 to 30. Mean = 13 sessions. **Content:** Included general knowledge about HIV/AIDS, training in coping skills (including unrealistic expectation in high-risk situations), access to health care and other resources, and methods of surmounting individual barriers (covered in private counseling). Activities were interactive (e.g., developed raps and soap opera dramatizations and practiced behavioral coping responses). **Methods:** Taught in small groups (N=10) 4 days per week by male and female team of trained leaders.	Quasi-experimental. One shelter for runaway youth offered the program, while a second similar shelter in the same city serving similar youth did not. Matched interview data collected at baseline, 3 months later, and 6 months later. Intervention post-test: N=78 Comparison post-test: N=67	Outcomes were regressed onto the number of sessions that runaways participated in and demographic variables. There were no significant differences between the 2 groups at baseline.	At 3 months: Abstained from sex: 0 Consistent condom use: + Avoidance of high-risk situations: + At 6 months: Abstinence: 0 Consistent condom use: + Avoidance of high-risk situations: +	Several things reduced the validity of this design: the lack of random assignment; the use of only two groups; the relatively small sample size; and the failure to adequately control for other differences between those youth who remained in the shelter for longer periods of time and those who remained for shorter periods. On the other hand, there were no significant differences in demographic characteristics or sexual risk behaviors at baseline between the two groups, and the magnitude of the effects appeared large.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.3: Studies of HIV/AIDS Education Programs *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Untitled Slonim-Nevo, Auslander, Ozawa, Jung 1996	St. Louis, MO Not reported N=218	Mean=14.7 years Not reported M=56% F=44% Wh=54% Bl=46%	**Setting:** Residential centers for youth who had been delinquent, abused, or neglected or had mental health problems. **Sessions:** 9 1.5-2 hour sessions delivered over a 3-week period. **Content:** Based on cognitive-behavioral theory. Substantive HIV content the same for both. The skills-based group was taught skills using modeling, demonstrations, role plays, and practice, while the discussion group was taught using problem solving and discussions. **Methods:** Taught in small groups (8-10) of same age and gender. Two facilitators per group.	Experimental. 15 residential centers were randomly assigned to skills training group, discussion-only group, or control group. Matched questionnaire data were collected at baseline, post-test, and 9-12 months.	Analysis of covariance with baseline scores of outcome variables as covariates. General linear models for continuous outcome variables and logistic models for dichotomous.	Sex with an unknown partner: 0 Vaginal sex without condom: 0 Anal sex without condom: 0	This was a strong evaluation design with random assignment, long-term follow-up, multiple outcome measures, and sophisticated statistical analysis. The sample size was modest, but results were not consistently in the desired direction nor close to significance.
Youth AIDS Prevention Project (YAPP) Levy, Perhats, Weeks, Handler, Zhu, Flay 1995 Weeks, Levy, Gordon, Handler, Perhats, Flay 1997	Chicago, IL Low SES N=1,669	Not reported 7th graders M=49% F=51% Bl=59% Wh=24% His=13% Othr=4%	**Setting:** School classrooms. **Sessions:** 10 in 7th grade, 5 in 8th grade booster. **Content:** Based on social learning theory; topics included HIV/AIDS/STD prevention, pregnancy prevention, decision-making, and resistance/negotiation skills. Activities included lectures, class discussions, small group exercises, role plays, educational competitions, and an anonymous question box. **Methods:** Instruction was implemented by professional health educators.	Experimental. Fifteen school districts were randomly assigned to the first treatment group, which included classroom instruction plus parent activities, a second treatment group, which received classroom instruction, and the control group, which received the standard AIDS curriculum. Matched questionnaire data were collected before the intervention in the 7th grade, after the intervention booster in the 8th grade, and in the 9th grade. Intervention post-test: N=1,001 Control post-test: N=668	Significance tests showed no differences between groups at pre-test. Three-way ANOVAs controlling for race and gender, and logistic regression controlling for race and gender. Also random-effects regression to handle some missing data.	Initiation of intercourse: 0 Frequency of sexual activity: 0 Number of sexual partners: 0 Ever used condoms: 0 Condom use last sex: 0	Large groups of students were randomly assigned (school districts), but analyses were conducted at the individual level. Attrition rates were high (56%) by 9th grade. Post-test may have occurred shortly after the 8th grade intervention, not allowing for a decline in the impact or for a possible delay in initiation of intercourse to be measured.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.9: Studies of Community-Wide Pregnancy or HIV Prevention Initiatives with Multiple Components

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Condom Campaign Alstead, Campsmith, Halley, Hartfield, Goldbaum, Wood 1999	3 King County (Seattle) communities Not reported N=1,425	15=34% 16=35% 17=31% Not reported M=49% F=51% Wh=40% Bl=26% Asn=18% Oth=16%	**Setting:** 3 communities **Content:** 3 primary strategies: (1) mobilization of multiple levels of the community to support the campaign; (2) a mass media campaign targeting sexually active teens using pamphlets, posters, t-shirts, radio spots, bus signs, and billboards; and (3) recruitment of multiple agencies, organizations, and businesses to distribute condoms from 22 bins or 25 vending machines in restrooms and other locations.	Quasi-experimental. Cross-sectional interview survey data collected before the campaign, 2 months later (after the first wave of the media campaign), and 7 months later (after the second wave). Samples selected from convenience sites where youth congregated. Baseline: N=341 2-month: N=478 7-month: N=606	Chi-square or Fisher's exact test were used to compare pre- and post-test proportions.	Ever had sex: 0 Sex in last 90 days: 0 Use of condoms: 0	This was a challenging design, because it attempted to measure the impact of the campaign upon all sexually active youth in the communities, not just upon those who observed the campaign. The validity of the study was reduced by the lack of random assignment and no comparison group. There were also no significant differences in condom use (or in intent to use condoms) between those who reported exposure to the campaign and those who did not.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change =.–.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.9: Studies of Community-Wide Pregnancy or HIV Prevention Initiatives with Multiple Components *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Plain Talk Grossman, Pepper 1999	Atlanta, GA; New Orleans, LA; San Diego, CA Low SES N=1,268	12-13=32% 14-16=41% 17-18=27% Not reported M=50% F=50% Bl=58% His=40% Oth=2%	**Setting:** 3 communities **Content:** Designed to: (1) create a consensus among adults about the need to protect sexually active youth by encouraging contraceptive use; (2) provide parents and other community adults with the knowledge and skills to communicate more effectively with teen about sexual behavior and contraception; and (3) improve access to reproductive health care, including contraception. A clinic was opened in one community; an adolescent clinic opened in the evening in a second, and a clinic increased its hours in the third. Community events were implemented and reproductive health information provided.	Quasi-experimental. Cross-sectional survey data were collected before the intervention and again 3 years later (1 site) or 4 years later (2 sites).	Logistic regression.	Use of birth control at first sex: All: 0 Girls: 0 Boys: 0 Use of birth control at last sex: All: 0 Girls: 0 Boys: 0 Pregnancy: All: 0 Girls: + Boys: 0	This was a challenging design, because it attempted to measure the impact of the campaign upon all sexually active youth in the communities, not just upon those who observed the campaign. The strength of the evidence was reduced by the long period of time between pre and post surveys and inability to control well for the many other changes that took place both nationally and locally during that time (e.g., changes in local school health education programs, statewide pregnancy prevention initiatives, welfare reform, national teen sexual behavior, and national teen pregnancy rates). Pre and post surveys were also conducted at different times of the year. The analysis of the pregnancy rates did not adjust for decreases in national pregnancy rates.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.9: Studies of Community-Wide Pregnancy or HIV Prevention Initiatives with Multiple Components *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Poder Latino Sellers, McGraw, McKinlay 1994	Boston, MA, and Hartford, CT Low SES N=536	Mean=16.9 years Not reported Not reported His=100% Puerto Rican= 94%	**Setting:** School and community. **Sessions:** 18-month program. **Content:** Workshops run by peer educators in schools, community organizations, and health centers; group discussions in homes; presentations at large community events; door-to-door and street corner canvassing; provision of condoms; radio and TV PSAs; posters; quarterly newsletters.	Quasi-experimental. Areal probability samples selected in the inner-city areas of Boston (with the intervention) and Hartford (without the intervention). Interviews conducted before and after the intervention (18 months later).	Multivariate regression and logistic regression were used to control for differences between the two samples. There were pre-test differences between the two groups in whether they had ever had an STD or knew someone with AIDS. Males and females were analyzed separately.	Initiation of intercourse: Males: + Females: 0 Having multiple partners during the previous 6 months: Males: 0 Females: + Frequency of sex in previous 6 months: Males: 0 Females: 0 Use of condom during last intercourse: Males: 0 Females: 0 Proportion of time a condom used: Males: 0 Females: 0	This was not a strong design, because basically two different cities were being compared and other factors could have contributed to these outcomes (or lack of outcomes). However, many baseline differences were controlled statistically, and change over time was measured. Samples sizes for subsets of youth (sexually inexperienced at pre-test) were small (e.g., 89 inexperienced males). The percentage of youth who had participated in AIDS workshops and programs was similar in both cities, but more youth had received free condoms in Boston.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.9: Studies of Community-Wide Pregnancy or HIV Prevention Initiatives with Multiple Components *continued*

Study Information	Sample Description		Study		Results		
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Project ACTION Poten, Freeborn 1995	Portland, OR Not reported N=2,212	12-21 years Median=15-16 years Not reported M=58% F=42% Wh=42% Bl=35% His=5% AmInd=4% Asn=2% Othr=12%	**Setting:** Community. **Content:** The intervention included: (1) a community mobilization to increase community acceptance of efforts to increase teen condom use; (2) a media campaign involving 3 PSAs airing on TV; (3) the installation of 240 condom vending machines in locations recommended by youth; and (4) a teen skills-building workshop program.	Quasi-experimental. Cross-sections of teen clients of local agencies serving youth at higher risk of STDs were interviewed before the intervention began and continuously thereafter for about 2 years. Baseline: N=508 Post intervention: N=1,704	Used regression and logistic regression to assess change over time, controlling for gender, age, race, and number of sexual partners.	Initiation of intercourse: 0 Acquired a condom in the last month: 0 Used a condom at last intercourse with main partner: 0 Used a condom at last intercourse with other or casual partner: +	This was a challenging design, because it attempted to measure the impact of the campaign upon all youth in youth-serving agencies, not just upon those who observed the campaign. The validity of the study was reduced by the lack of random assignment, some differences among the different cross-sectional samples of youth, and the relatively small sample sizes for youth who had sex with casual partners. It was not possible to link the short-term increase in condom use with the campaign. Teens familiar with the PSA or logo were not more likely to use a condom than those teens not familiar. Attitudes toward condoms and self-efficacy regarding condom use improved.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.9: Studies of Community-Wide Pregnancy or HIV Prevention Initiatives with Multiple Components *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
RESPECT (Responsible Education on Sexuality and Pregnancy for Every Community's Teens) Hughes, Furstenberg, Teitler 1995 Note: This study also appears in Table 4.6	Philadelphia, PA Cross-section of city N=1,961	14-18 years Not reported Not reported Not reported	**Setting:** 9 family planning clinics and their communities. **Sessions:** Not reported. **Content:** Clinics initiated or expanded after-school or evening hours, began teenage walk-in hours, decreased the average waiting time for appointments, and increased the hours reserved for teenagers only. They also trained the staff to work with teens. In addition, the initiative conducted school and community activities, as well as a media campaign.	Quasi-experimental. Random samples of teens from the entire catchment areas of the clinic were compared with random samples of teens from the entire city excluding the catchment areas. Telephone interviews with teens before the program was initiated and about 2.5 years later. Wave 1 pre-test: N=907 Wave 1 post-test: N=117 Wave 2 pre-test: N=680 Wave 2 post-test: N=257	Logistic regression was used to control for age, race, and gender, and to measure change over time in the catchment area versus that in the remainder of the city.	Initiation of intercourse: 0 Frequency of sex: 0 Use of contraception: 0 Pregnancy rates: 0 Birth rates: 0	This study measured the impact upon the entire targeted population, not just upon those actually receiving services; this is a much more demanding outcome criterion. Some program components (e.g., the media component) may have reached the comparison group as well.
School/Community Program for Sexual Risk Reduction Among Teens Vincent, Clearie, Schluchter 1987 Koo, Dunteman, George, Green, Vincent 1994	Rural county in South Carolina Low SES N=3,800 to 4,430, depending upon year	14-17 years Not reported F=100% Bl=58% Wh=42%	**Setting:** K-12 classrooms. **Sessions:** Integrated into other instruction. **Content:** About two-thirds of the school staff were given sex education training. Classroom instruction was designed to increase knowledge, decision-making skills, communication skills, and self-esteem, and to align values with those of the community. The focus was not always on sexuality but upon problem-solving, risk assessment, and assuming personal responsibility. Peer education was included. School nurse provided consultation, condoms, and transportation to a family planning clinic. Community groups and churches implemented classes and special events. Articles appeared in papers, and announcements were on the radio.	Quasi-experimental. Annual pregnancy rates for 14- to 17-year-old females were estimated for the years 1977-1988 for: (1) the western part of the county surrounding the program community; (2) the eastern part of the county serving as a comparison group; and (3) 3 similar counties serving as comparison groups. Intervention: N=range from 319 to 333 Comparison: N=range from 391 to 1,630	Z statistic for proportional differences in pregnancy rates was used to compare intervention and comparison groups.	Pregnancy rates: +	This was a challenging design, because it attempted to measure the impact of the program upon all youth in the community, not just upon those who received interventions. After the program was implemented, pregnancy rates declined; after parts of the program ended, pregnancy rates returned to their previous level. The small number of years and the small number of 14- to 17-year-old females limit the internal validity of these findings. The very small population and the geographical isolation of the county limit its external validity. It is not clear what parts of the program were most important.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.9: Studies of Community-Wide Pregnancy or HIV Prevention Initiatives with Multiple Components *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
School/Community Sexual Risk Reduction Replication Initiative Paine-Andrews, Harris, Fisher, Lewis, Williams, Fawcett, Vincent 1999	3 Kansas communities: Geary, Franklin, Wichita Mixed SES	Not reported Not reported Not reported Geary: Wh=66% Bl=23% His=6% As=4% Franklin: Wh=97% His=2% Bl=1% Wichita: Not reported	**Setting:** Communities and schools, clinics and organizations within them. **Content:** Community-wide initiatives included: enhanced sexuality education for teachers and parents, age-appropriate sex education (K-12), increased access to health services, collaboration with school administrators, use of mass media, greater involvement of community in teen pregnancy prevention, peer support and education, alternative activities for youth, and involvement of the faith communities.	Quasi-experimental. The intervention zip codes were matched with other zip codes to form comparison groups. In Geary and Franklin, questionnaire data were collected in schools in the intervention areas before and after the intervention. In all these communities, birth rate data were collected for up to 5 years before the intervention and 3 years during, in both the intervention and comparison zip codes. Geary: Pre-test N=1,004 Post-test N=952 Franklin: Pre-test N=710 Post-test N=817	Chi-square tests for behavioral data; an adjusted z-statistic for pregnancy and birth rate data.	Ever had sex: Geary: + Franklin: – Age at first sex: Geary: 0 Franklin: 0 Condom use: Geary: 0 Franklin: + Pregnancy: Geary: 0 Franklin: 0 Births: Wichita: 0	This was a challenging design, because it attempted to measure the impact of the program upon all youth in the community, not just upon those who received interventions. It employed a theory of change evaluation strategy. Process data indicated numerous school and community changes. Conclusions are limited by various design limitations and results that differed across the sites. Changes in pregnancy and birth rates were not consistently favorable, and never statistically significant, but tended to favor the intervention zip codes.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.11: Studies of Service Learning Programs

Study Information	Sample Description		Study		Results		
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Learn and Serve America Melchior 1998	Seventeen communities in U.S.	Not reported 7th-8th=30% 9th-12th=70% M=40% F=60% Wh=58% His=19% Bl=17% Oth=6%	**Setting:** Middle and high schools. **Content:** Service learning projects included: (1) "meaningful" service in the community (e.g., tutoring, working as a teacher's aide, working in a nursing home, or homeless shelter) for a mean of 77 hours; and (2) structured time for reflection (discussions, journal writing, papers, and group presentations). Both parts are linked to the academic curriculum. Only well-designed and high quality programs were selected.	Quasi-experimental. Comparison groups were other similar classes in the same school or classes in other schools. Questionnaire data were collected at baseline, after program participation (end of school year), and one year after participation (end of following school year). Intervention group: N=608 Comparison group: N=444	ANCOVA, controlling for baseline differences, and ANCOVA using change scores.	Pregnancy: 0	This strength of this design was weakened by possible self-selection effects. There was an impact upon pregnancy at the p=.10 level at post-test, but not the one-year follow-up test. At post-test, the program also had a small positive impact upon educational attitudes and some measures of school performance, but these did not last through the following year.
Reach for Health and Community Youth Service Learning O'Donnell, Stueve, Doval, Duran, Haber, Atnafou, Johnson, Grant, Murray, Juhn, Tang, Piessens 1999 (See next entry)	New York Low SES N=1,061	Mean age=12.7 years 7th=52% 8th=48% M=47% F=53% Bl=79%	**Setting:** Middle schools. **Sessions:** 40/year for Reach for Health, plus 3 hours/week for community service. **Content:** Community Youth Service (CYS) included service in nursing homes, neighborhood clinics, child day care centers, and a senior citizen center. Each student was assigned to 2 locations. Students debriefed experiences. Reach for Health (RFH) focused on substance use, violence, and sexual behavior.	Part experimental, part quasi-experimental. Thirty-five classrooms of students were randomly assigned to receive Reach for Health plus community service or only Reach for Health. Another school was matched as a comparison school. Matched questionnaire data collected in fall (baseline) and spring (follow-up). RFH & CYS: N=255 RFH: N=222 Comparison: N=584	MIXOR used to control for baseline scores. Adjusted for clustering.	CYS & RFH vs. Control Had sex in last 3 months: + RFH vs. Control Had sex in last 3 months: 0	The strength of the design was reduced by lack of random assignment to the control group, small sample sizes, modest long-term follow-up, and an absence of tests of significance for some outcomes. The greatest effect was upon 8th graders (as opposed to 7th graders). Trend data indicated that the greatest impact was also upon youth in special education classes.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.11: Studies of Service Learning Programs *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Reach for Health and Community Youth Service Learning O'Donnell, Stueve, O'Donnell, Duran, Doval, Wilson, Haber, Perry, Pleck Unpublished (2000) (See previous entry)	New York Low SES N=195	Not reported 7th=100% M=41% F=59% Bl=71% His=26% Oth=3%	**Setting:** Middle schools. **Sessions:** 3 hours/week for 30 weeks community service or 90 hours altogether. **Content:** Community Youth Service (CYS) included service in senior citizen homes, nursing homes, health centers, and child day care centers. Each student was assigned to 2 locations. Students debriefed experiences. Reach for Health (RFH) focused on substance use, violence, and sexual behavior.	Experimental. Eighteen classrooms of students were randomly assigned to receive Reach for Health plus community service or only Reach for Health. Matched questionnaire data were collected in fall of the 7th grade (baseline) and spring of the 10th grade (follow-up).	Logistic regression, adjusted for the clustering of students in classrooms.	Initiation of sex: + Had sex in last month: +	A few students transferred into or out of the program because of expanded resources or scheduling conflicts.
Teen Outreach Program (TOP) Philliber, Allen (#1) 1992 Allen, Philliber, Herrlin, Kuperminc (#2) 1997	**Study #1:** 150 sites nationwide Mixed SES **Study #2:** 25 sites nationwide Mixed SES	**Study #1:** 11-19 years Middle and high schools Not reported Not reported **Study #2:** Mean age: 15.8 years 9th=36% 10th=33% 11th=20% 12=11% M=15% F=85% Bl=67% Wh=19% His=11% Oth=3%	**Setting:** Schools and communities in many sites throughout the country. **Sessions:** Weekly. **Content:** 2 major components: (1) small group classroom discussions of values, decision-making, communication skills, parenting, life options, and volunteer experiences; and (2) volunteer service in school or community, e.g., served as aides in hospitals and nursing homes, participated in walkathons, peer tutoring, and other activities. A minimum of 20 hours of service, but mean was 46 hours.	**Study #1:** Quasi-experimental. Comparison group selected by TOP participants, TOP or school staff, or random assignment. Matched questionnaire data were collected at intake and exit from program (beginning and end of school year). Intervention post-test: N=2,624 Comparison post-test: N=3,032 **Study #2:** Experimental. Matched questionnaire data were collected during first several weeks of school year and end of school year. Intervention post-test: N=342 Comparison post-test: N=353	Two groups were compared, controlling for baseline differences in problem behaviors and other characteristics.	**Study #1:** Pregnancy rates: + **Study #2:** Pregnancy rates: +	The second study had a strong experimental design. It confirmed the results found in the first study which had a weaker design. Neither study measured long-term results. The program also reduced course failure and school suspensions.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.12: Studies of Vocational Education and Employment Programs

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Conservation and Youth Service Corps Jastrab, Blomquist, Masker, Orr 1997	Four cities throughout the country Low SES Not reported	18-25 years Out of school M=57% F=43% Bl=50% His=25% Wh=14% As=5% Oth=6%	**Setting:** Communities. **Duration:** About 4-5 months on average. **Content:** Provides remedial, vocational and academic education, and work experience within the context of community service (about 80% community service and 20% education and other activities). Corps members work full time in small teams. Community projects last 2-12 weeks, e.g., provide assistance to nursing homes, help renovate low-income housing or complete environmental projects.	Experimental. Individual youth were randomly assigned to the corps or to nothing. Interview data were collected at baseline; telephone interview data collected 15-months later. Sample size not reported.	Not reported.	Unmarried pregnancy: Overall: 0 Black females: + Hispanic females: 0 White females: 0	The evaluation had a strong design, but the impact upon pregnancy was not in the same direction for all ethnic groups. Intervention group had other positive outcomes, such as lower arrest rates and higher rates of paid employment.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.12: Studies of Vocational Education and Employment Programs *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Job Corps Schochet Burghardt Glazerman 2000	119 communities in the U.S. Low income N=11,787	16-17=44% 18-19=30% 20-24=26% Not reported M=57% F=43% Bl=49% Wh=26% His=17% Oth=7%	**Setting:** Mostly residential, but a few non-residential Job Corps settings. **Content:** An intensive, comprehensive program whose major service components include academic education, vocational training, residential living, health care, health education, counseling, and job placement assistance. Mean number of months of participation was 8 months. Mean number of hours of academic and vocational instruction was greater than 1,000.	Experimental. A random sample of youth eligible to participate in Job Corps nationwide were selected for the study. They were randomly assigned to Job Corps and control groups. Control group members could participate in other programs (mean is 637 hours of programs). Interview data were collected at baseline, 12 months, and 30 months. Intervention group: N=7,311 Control group: N=4,476.	Chi-square and t-tests. Appropriate sample weights.	Birth rates: 0	This was an extremely strong experimental design: random sample of U.S. eligible participants, random assignment to group, long-term follow-up, and measurement of births. Many control group members participated in other similar types of programs. Job Corps participation led to more GED completion, higher earnings after 2 years, lower employment during Job Corps and higher employment after 2 years, lower receipt of public assistance, and lower arrest and conviction rates, but most effects were very small. There were no significant changes in college attendance and substance use. Note the sample was much older at the 30-month follow-up survey.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.12: Studies of Vocational Education and Employment Programs *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
JOBSTART Cave, Bos, Doolittle, Toussaint 1993	13 cities in U.S. Low income N=1,941	16-19=73% 20-21=27% School dropouts M=46% F=54% Bl=44% His=44% Wh=9% Oth=3%	**Setting:** Community organizations, schools, and Job Corp settings. **Content:** Included individualized instruction in basic academic skills, occupational training, support services (i.e., transportation, child care, counseling, life skills), and job placement assistance. Mean of 400 hours of activities.	Experimental. Youth who applied for the program were randomly assigned to participate or not. The control group could and did receive services from other programs. Survey data were collected at baseline, 12, 24, and 48 months. Intervention group: N=533 Control group: N=496	t-tests.	Non-custodial women: Pregnancy rates: 0 Birth rates: 0 Custodial mothers: Pregnancy rates: – Birth rates: –	This was a strong experimental design. JOBSTART led to increases in GED completion and lower earned income during JOBSTART participation. There was a significant increase in childbearing among women who were custodial mothers when they entered (about half), but no difference among those who were not custodial mothers when they entered. Note the sample was much older at the 4-year follow-up survey.
Summer Training and Education Program (STEP) Walker, Vilella-Velez 1992 Grossman, Sipe 1992	5 urban areas in the U.S. Low SES, (academically behind) N=4,800	14=57% 15=43% Not reported M=48% F=52% Bl=49% Asn=19% His=18% Wh/ Othr=14%	**Setting:** Classroom and part-time jobs. **Sessions:** 36 sessions over 2 summers. **Content:** Life skills education in such areas as sexual behavior, drug use, careers, and community involvement. In sexuality, it focused on decision-making and the importance of responsible behavior. Ninety hours of work (half-time) at minimum wage, 90 hours of academic recitation, and 5-15 hours of support during the school years.	Experimental. Random assignment to the STEP program or to a guaranteed job during the summer. Matched questionnaire data were collected annually for 5 years. Treatment: N=2,400 Control: N=2,400	Not reported.	Sexual activity: 0 Use of contraceptives: 0 Births: 0	The evaluation was very rigorous; it had random assignment, large sample sizes, and long-term follow-up. It should be recognized that the control group received full-time jobs (rather than half-time jobs) during the summer.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.13: Studies of Other Youth Development Programs

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Quantum Opportunities Program Hahn, Leavitt, Aaron 1994	San Antonio, TX; Philadelphia, PA; Milwaukee, WI; Saginaw, MI; and Oklahoma City, OK Low SES N=149	Not reported 9th graders Not reported Not reported	**Setting:** Community youth-serving agencies **Content:** Included educational activities (e.g., tutoring and computer-based instruction), community service activities, and development activities (arts, career, and college planning). Participants received small stipends and bonus payments for participation and completion of activities.	Experimental. In each of the 5 sites, 50 students were randomly assigned to treatment and control conditions. Follow-up questionnaire data were collected 6 times over 4 years.	Means for 2 groups were compared.	Birth rates: 0	Aside from the relatively small sample size, this was a strong evaluation design. While there were no significant effects upon birth rates at the p=.05 level for the first 3 years, after 4 years there was a positive effect on birth rates at the p=.09 level.
Seattle Social Development Project Hawkins, Catalano, Kosterman, Abbott, Hill 1999	Seattle, WA Low SES=57% N=598	Not reported Not reported M=50% F=50% Wh=44% Oth=56%	**Setting:** Elementary schools. **Content:** Designed to increase attachment to school and family by improving teaching strategies and parenting skills. Also designed to increase children's social skills (e.g., decision-making and refusal skills). Grades 1-6: 5 days of in-service training for teachers each year; parenting classes for parents of children in grades 1-3 and 5-6, and social competence training for children in grades 1-6.	Quasi-experimental. Eighteen schools were non-randomly assigned to treatment and control; classrooms within some schools randomly assigned to treatment and control. Interview data collected at age 18.	Analysis of variance for continuous variables; chi-square test for dichotomous measures. Logistic and linear regression also used.	Ever had sex: + Number of sex partners: + Pregnancy: +	The strength of this design was weakened by the lack of random assignment. Intervention group had other positive outcomes, such as fewer delinquent acts, less drinking, less school misbehavior, more attachment to school, and higher academic achievement.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.14: Studies of Multi-Component Programs with Both Sexuality and Youth Development Components

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
California's Adolescent Sibling Pregnancy Prevention Program East, Kiernan 2000	16 locations in California Not reported N=1,270	Mean=13.7 years Mean grade=8.2 M=40% F=60% His=68% Bl=11% Wh=11% Oth=10%	**Settings:** Multiple settings, including schools, health departments, and social service agencies. **Sessions:** An average of 18.4 hours. **Content:** All 44 sites were different. Multiple strategies were used, e.g., individual case management and group services. Programs were designed to increase self-esteem, help youth remain in school or return to school, improve knowledge and skills to make healthy decisions, improve access to health and reproductive services, and increase communication with parents and adults. They were also designed to delay sex, increase contraceptive use, and decrease risk behaviors associated with teen pregnancy (e.g., drinking and drug use). Programs included recreation.	Quasi-experimental. All study participants had to meet certain criteria. Comparison group members were often selected from the waiting list (were deemed at lower risk) and found through outreach efforts. Matched questionnaire data were collected at baseline and 9 months later. Intervention post-test: N=821 Comparison post-test: N=450	Analyses statistically controlled for differences in background characteristics and for participation in other non-ASPPP services.	Initiation of sex: + Frequency of sex: 0 Number of sexual partners: 0 Consistency of contraceptive use: 0 Pregnancy: Girls: +	The strength of this design was weakened by lack of random assignment and possible self-selection effects. However, the intervention youth appeared at higher risk on some indices. Youth who received greater numbers of hours of service were less likely to initiate sex, more likely to use contraception, and less likely to become pregnant, but possible self-selection differences were not statistically controlled.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.14: Studies of Multi-Component Programs with Both Sexuality and Youth Development Components *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Children's Aid Society Carrera Program Phillibar, Kaye, Herrling, West 2000	New York, NY Low SES N=484	13=36% 14=37% 15=26% Not reported M=45% F=55% Bl=56% His=36% Bl&His=7% Oth=2%	**Setting:** Community organizations serving youth. **Sessions:** 5 days a week during the school year, and special sessions in the summer. Mean number of hours of participation for first 3 years was 16 hours per month. **Content:** This was an intensive program lasting through high school. It used a holistic approach, and staff tried to develop close relationships with youth. It included 5 components: (1) family life and sex education; (2) an education component that included individual academic assessment, tutoring, help with homework, preparation for standardized exams, and assistance with college entrance; (3) a work-related intervention that included a job club, stipends, individual bank accounts, employment, and career awareness; (4) self-expression through the arts; and (5) individual sports. In addition, the program provided mental health care and comprehensive medical care, including contraception.	Experimental. In each of the 6 sites, youth were randomly assigned to treatment and control conditions. Some control group members received a few after-school services, typically recreation. Matched questionnaire data were collected at baseline and annually for 3 years. Three-year data reported. Intervention 3-yr: N=242 Control 3-yr: N=242	Logistic regression, separate for each gender, controlling for a few baseline characteristics.	Ever had sex: All: + Girls: + Boys: 0 Condom use at last sex: All: 0 Girls: 0 Boys: 0 Use of condom plus an effective method of contraception: All: 0 Girls: + Boys: – Pregnancy: All: + Girls: + Boys: 0 Births: All: 0 Girls: + Boys: 0	This was a very rigorous study with multiple sites, random assignment, a large sample size, long-term measurement, measurement of behavior, and, among females, positive findings for sexual behavior and pregnancy (as opposed to only behaviors affecting pregnancy). Notably, the findings are reported for all the members of the treatment and control groups, even though some members of the treatment group did not participate much and some members of the control group participated in some services. Positive effects upon sexual behaviors and outcomes were limited to girls and did not extend to boys. In other areas, there were a few positive effects for both girls and boys (e.g., work experience, bank accounts, and receipt of some health services).

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Table 4.14: Studies of Multi-Component Programs with Both Sexuality and Youth Development Components *continued*

Study Information	Sample Description		Study			Results	
Program(s) / Author(s) / Publication Date	Location / SES / Post Sample (N)	Age / Grade / Gender / Ethnicity	Program Description	Design	Analytic Methods	Change in Outcome[1]	Additional Comments
Untitled McBride, Gienapp 2000	Washington state Low SES N=690	Mean=15.4 years Not reported M=10% F=90% Wh=74% Oth=26%	**Setting:** There were 3 programs which were administered in a family planning clinic, a middle and high school, and a community-based setting. One was run by the health department and two were run by family planning clinics. **Sessions:** Mean=27 hours. **Content:** Employed a "client-centered" approach that is based upon the service providers' beliefs about why teens become involved in risky sexual behaviors, e.g., they lack: (1) information about sex; (2) adults whom they can trust; (3) coping skills; (4) emotional support; and (5) positive guidance. The approach addresses these and other problems by combining small group and individualized education and skill-building with other individualized services such as counseling, mentoring, referrals, and advocacy tailored for each teen.	Experimental. Individual youth were randomly assigned. Control group received only 2 hours of program services. Matched questionnaire data were collected at baseline and 6 to 9 months later at end of intervention. Intervention group: N=191 Control group: N=166	t-tests for baseline differences. Covariance adjustment model.	Ever had sex: 0 Sex in past month: + Contraceptive use during last month: 0 Contraceptive use during last sex: 0 Always use contraceptives: 0	The study evaluated 7 programs/sites, but only 3 measured impact upon behavior. This was a strong experimental design, but its strength was weakened by small sample sizes for some analyses.

1 Change in outcome for group receiving intervention: no significant change = 0; significant desirable change = +; significant undesirable change = –.

Note: For all studies, the significance level was set at $p < 0.05$. If authors reported significant findings at the $p < 0.10$ level, they were treated as insignificant in this table.

Family PACT Overview. Volume I. California Department of Health Services, Office of Family Planning. 2001.

Family PACT

Planning • Access • Care • Treatment

Family PACT Overview

About Family PACT

Family PACT is California's innovative approach to provide comprehensive family planning services to low-income men and women. The goals of this new public health program are to promote optimal reproductive health and to reduce unplanned pregnancy by lowering the barriers that many men and women with unmet need face in obtaining family planning services. The program fills a critical gap in health care for under-insured and uninsured Californians.

Background

In 1996, California enacted legislation to create Family PACT, a reproductive health program for clinical family planning services. A five-year federal Medi-Cal Demonstration Project waiver was granted effective December 1, 1999, allowing access to federal matching funds. The Family PACT Program is administered by the Department of Health Services' Office of Family Planning.

Family PACT Providers

Family PACT has increased access to family planning services by expanding the provider network. By the beginning of 2000, there were more than 2,600 clinic and private practice clinician provider entities. Family PACT clinician providers include private physicians in individual or group settings, nonprofit community-based clinics, OB/GYNs and physicians representing general practice, family practice, internal medicine and pediatrics. Medi-Cal licensed pharmacies and laboratories also participate by referral clinicians.

Provider Enrollment & Reimbursement

Licensed Medi-Cal providers in good standing are eligible to serve clients once they have attended a mandatory Orientation Session and have an accepted Application and Enrollment Agreement. Licensed Medi-Cal pharmacies and laboratories are not required to submit an Application and Agreement or attend an Orientation Session. Reimbursement is generally consistent with California's Medi-Cal fee-for-service rates. Payment is limited to services defined by the program.

Client Eligibility & Enrollment

Family PACT clients are male and female residents of California with a family income at or below 200 percent of the federal poverty level with no other source of family planning coverage. Clients are individuals at risk of pregnancy or causing pregnancy who do not qualify for Medi-Cal and do not have access to health insurance. Medi-Cal clients with an unmet share of cost may also be eligible. Eligibility determination and enrollment are conducted at the provider's office with point of service activation of a client membership card.

Client Benefits & Services

Family PACT provides comprehensive family planning services to men and women including all FDA approved forms of contraception, emergency contraception, pregnancy testing with counseling, preconception counseling, male and female sterilization, limited infertility services, STI testing and treatment, cancer screening, Hepatitis B immunization and HIV screening. Individual client reproductive health education and counseling is an ongoing component of all services.

California Department of Health Services • Office of Family Planning
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Volume 1

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"Power Through Choices Curriculum." A Summary. California Department of Health Services, Office of Family Planning.

POWER THROUGH CHOICES CURRICULUM

Introduction

Developed in1994 by the Family Welfare Research Group of the School of Social Welfare, University of California, Berkeley for the California Department of Health Services, Office of Family Panning, the *Power Through Choices* is an adolescent pregnancy/HIV/STI (sexually transmitted infection) prevention curriculum for youth (ages 14-18 years old) in out-of-home care. The youth may reside in group homes, foster homes, kinship foster care, or residential care settings; some out-of home care youth attend Independent Living Programs (ILP), court schools, and alternative schools.

In 1996, the California legislative mandate (AB 1127) was passed that required foster care providers of adolescents in long term out-of-home care to ensure that these youth receive age-appropriate pregnancy prevention information. Since 1997, OFP has contracted with agencies to implement the *Power Through Choices* curriculum.

Goals and Objectives

The curriculum's goal is to provide youth in out-of-home care with specific skills and information to help them avoid high-risk sexual behavior and reduce the incidence of adolescent pregnancy, HIV, and other STIs. The curriculum's objective are to enable participants to: (1) recognize and make choices related to sexual behavior; (2) build contraceptive knowledge and skills; (3) develop and practice effective communication skills; and (4) learn and practice locating and using local resources.

Overview of the Curriculum

The instructional approaches used in the *Power Through Choices* are based on research in behavior change and sex education. Two major themes: 1) self-empowerment and 2) the impact of choices on an individual's future are reinforced through highly interactive, practical, and skills building activities.

Power Through Choices focuses on recognizing and making choices related to sexual behavior, finding and using local resources, and developing effective communication skills. The curriculum emphasizes the importance of building skills related to effective contraceptive use and risk reduction techniques and provides numerous, diverse opportunities for practice.

Through role-plays and other interactive activities, participants practice making reproductive health choices related to various lifestyles and adhering to those choices. They identify the series of choices in attaining short and long-term

goals, learning how to decide about if and when they choose to become a parent, and making a personal plan for avoiding an unintended pregnancy.

The curriculum's characters, whose experiences and relationships reappear through the sessions, help participants personalize the messages and them of *Power Through Choices.* Photographs of youth who depict each of these characters accompany the curriculum and reinforce the relevance of the curriculums scenarios.

The curriculum consist of 10 (60-90 minute) session listed below:

Session 1: Introduction
Session 2: Choices: Creating the Future You Want
Session 3: Communication: Making Your Choices Stick
Session 4: Empowerment: Preventing STIs and HIV
Session 5: Empowerment: Learning About Protection
Session 6: Empowerment: Practice Makes Perfect
Session 7: Empowerment: Using Resources to Support your Choices
Session 8: Making Choices That Fit Your Lifestyles
Session 9: Parenting: Making an Informed Choices
Session 10: Empowerment: Demonstrating Your Skills and Knowledge

Information on how to obtain this curriculum, please contact:
Anna Ramirez M.P.H, Chief, California Department of Health Services at (916) 654-0357.

"State Minor Consent Statues: A Summary." Prepared by the National Center for Youth Law. April 1995.

State Minor Consent Statutes: A Summary

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CALIFORNIA MINOR CONSENT LAWS

A SUMMARY

LIST OF PROVISIONS

Age of Majority	Cal. Fam. Code §6500
Voting Age	Cal. Const. Art. 2, § 2
Drinking Age	Cal. Bus. & Prof. Code § 25658
Emancipated Minors	Cal. Fam. Code §§ 7002, 7050, 7120, 7122
Minor Living Apart	Cal. Fam. Code § 6922
Minor Parent	No specific provisions found
Married Minor	See "Emancipated Minors"
Pregnant Minor	No specific provisions found
Minor in the Military	See Emancipated Minors
Emergency Care	No specific provisions found
General Medical Care	No specific provisions found
Family Planning/Contraceptive Care	See "Pregnancy Related Care"
Pregnancy Related Care	Cal. Fam. Code § 6925
Abortion	Cal. Fam. Code § 6925; Health & Safety Code § 25958
VD/STD Care	Cal. Fam. Code § 6926
HIV/AIDS Care	17 CCR 2500; Cal. Health & Safety Code §§ 199.22 & 199.27
Drug/Alcohol Treatment	Cal. Fam. Code § 6929
Sexual Assault	Cal. Fam. Code §§6927 & 7928
Outpatient Mental Health Services	Cal. Fam. Code § 6924
Inpatient Mental Health Services	Cal. Welf. & Inst. Code §§ 6000(b); 6552; 6000 - 6002.30

SPECIFIC PROVISIONS

Age of Majority
Cal. Fam. Code § 6500
The age of majority is 18.

Voting Age
Cal. Const. Art. 2, § 2
The voting age is 18.

Drinking Age
Cal. Bus. & Prof. Code § 25658
The drinking age is 21.

MINOR STATUS

Emancipated Minors

Cal. Fam. Code § 7002

A person under age 18 is emancipated if:

- the person has entered into a valid marriage;
- the person is on active duty with the armed forces; or
- the person has received a declaration of emancipation under § 7122.

Cal. Fam. Code § 7050

An emancipated minor may consent to medical, dental, or psychiatric care, without parental consent, knowledge, or liability.

Cal. Fam. Code §§ 7120 and 7122

The court will emancipate a minor if it finds that:

- the minor is at least 14 years old;
- the minor willingly lives separate and apart from his/her guardian with his/her guardian's consent;
- the minor is managing his or her own financial affairs; and
- the source of the income is not derived from any activity declared to be a crime; and
- emancipation is in the minor's best interests.

Minors Living Separate and Apart

Cal. Fam. Code § 6922

A minor may consent to his/her own medical or dental care if:

- the minor is age 15 or older;
- the minor is living separate and apart from his/her parents or guardian with or without the consent of the parent or guardian and regardless of the duration of the separate residence; and
- the minor is managing his/her own financial affairs, regardless of the source of income.

A physician, surgeon, or dentist may advise the minor's parents of the treatment given or needed, without the consent of the minor, if the physician, surgeon, or dentist knows the whereabouts of the minor's parents on the basis of information given by the minor.

TYPE OF CARE

Pregnancy Related Care/Abortion

Cal. Fam. Code § 6925

A minor may consent to medical care related to the prevention or treatment of pregnancy. However, this section does not authorize sterilizations without parental consent or abortion without parental consent or court order. But see "Note" under Cal. Health & Safety Code § 25958.

Cal. Health & Safety Code § 25958

Except in a medical emergency, an unemancipated minor may only obtain an abortion with her written consent and the written consent of a parent or legal guardian.

An unemancipated minor may obtain an abortion without parental consent upon court order finding that either:

- she is mature enough to make the decision herself; or
- an abortion is in her best interest.

NOTE: In American Academy of Pediatrics v. Lungren, __ Cal. App. 3d. __ (1994), the requirement that minors seeking abortions first obtain parental consent or a court order was permanently enjoined. Throughout the pendency of the lawsuit, initially filed in 1987, the status quo has been maintained allowing minors to give their own informed consent to abortion. The California Supreme Court has agreed to hear the case.

VD/STD Care

Cal. Fam. Code § 6926

A minor age 12 or older who may have come into contact with a reportable infectious, contagious, or communicable disease or with a sexually transmitted disease, as determined by the Department of Health Services, may consent to medical care for the diagnosis or treatment of the disease. (A list of reportable disease, which includes AIDS, may be found in 17 CCR[1] 2500; a list of pertinent STD's may be found in 17 CCR 5151(a).)

HIV/AIDS Care

17 CCR 2500

AIDS is a reportable and communicable disease.

Cal. Health and Safety Code § 120990

No person shall be tested for HIV without his/her valid written consent.

Cal. Health and Safety Code § 121020

A minor under the age of 12 is deemed not competent to give consent for an HIV test.

For an incompetent minor, consent maybe obtained from a parent or guardian. However, if the minor is a dependent of the court, written consent for an HIV test may be obtained from the court.

Written consent shall only be obtained from someone other than the minor when it is necessary to render appropriate care or to practice preventive measures.

Drug/Alcohol Treatment

Cal. Fam. Code § 6929 See amended statute, attached

A minor age 12 or older may consent to medical care and counseling related to diagnosis and treatment of drug or alcohol related problems. The treatment plan shall include the involvement of the minor's parents, if appropriate, as determined by the treating professional. This section does not authorize methadone treatment without parental consent.

Sexual Assault

Cal. Fam. Code § 6928

A minor who may have been sexually assaulted may consent to medical treatment and diagnosis for sexual assault and to collection of medical evidence. However, the parents of the minor must be informed unless they are suspected of being responsible for the assault. (In addition, under child abuse reporting requirements, a sexual assault against a minor must be reported as suspected abuse.)

Cal. Fam. Code § 6927

A minor age 12 or older who may have been raped may consent to medical care related to diagnosis or treatment for rape and to collection of medical evidence.

Outpatient Mental Health Services

Cal. Fam. Code § 6924

A minor age 12 or older may consent to outpatient mental health treatment or counseling or to residential shelter services if:

- The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient or residential services; and
- The minor either would present a danger of serious physical or mental harm to self or others without the mental health treatment or counseling or residential shelter services or is the alleged victim of incest or child abuse.

[1] CCR = California Code of Regulations

A professional offering residential shelter services is required to make his or her best efforts to notify the parent or guardian of the provision of services to the minor.

The mental health treatment or counseling of the minor must include the involvement of the minor's parent or guardian, unless in the opinion of the treating professional, it would be inappropriate and this is documented in the record.

This section does not authorize a minor to receive convulsive therapy or psychosurgery or psychotropic drugs without the consent of the minor's parent or guardian.

Inpatient Mental Health Services

Cal. Welf. & Inst. Code § 6000(b)

Application for voluntary admission for a minor to a state mental hospital must be made by the parent(s), guardian, conservator, or other person entitled to his or her custody.

In re Roger S., 19 Cal. 3d 921, 141 Cal. Rptr. 298 (1977)

A minor age 14 or older, voluntarily committed [by a parent] to a state hospital under Section 6000(b), is entitled to a due process hearing before a neutral factfinder to determine whether a basis exists for his or her confinement.

In re Michael E., 15 Cal. 3d 183, 123 Cal. Rptr. 103 (1975)

A minor ward of the juvenile court may not be admitted to a state mental hospital by order of the court except pursuant to the procedural safeguards provided for in the Lanterman-Petris-Short (LPS) Act, Welf. & Inst. Code §§ 5000 et seq.

Cal. Welf. & Inst. Code § 6552

Any minor under the jurisdiction of the juvenile court as a dependent, status offender, or delinquent may, *with advice of counsel*, make voluntary application for inpatient or outpatient mental health services. To authorize such voluntary application, the juvenile court must find:

- that the minor suffers from a mental disorder which may reasonably be expected to be cured or ameliorated by a course of treatment offered by the hospital or facility; and
- there is no other available hospital, program, or facility which might better serve the minor's medical needs and best interest.

Cal. Welf. & Inst. Code §§ 6000 - 6002.30

Minors have statutory rights to an independent clinical review of the necessity for their continued inpatient treatment, to receive a written explanation of their rights, and to consult with a patients' rights advocate. Parents must be advised of a variety of issues regarding use of restraints, seclusion, medication and family involvement. A minor who is admitted voluntarily may leave after notice is given by a parent. When a minor in a mental institution reaches the age of majority he or she must reapply for admission as an adult or be released.

§ 6929. Diagnosis or treatment of drug and alcohol abuse; liability for cost of services; disclosure of medical information

(a) As used in this section:

(1) "Counseling" means the provision of counseling services by a provider under a contract with the state or a county to provide alcohol or drug abuse counseling services pursuant to Part 2 (commencing with Section 5600) of Division 5 of the Welfare and Institutions Code or pursuant to Division 10.5 (commencing with Section 11750) of the Health and Safety Code.

(2) "Drug or alcohol" includes, but is not limited to, any substance listed in any of the following:

(A) Section 380 or 381 of the Penal Code.

(B) Division 10 (commencing with Section 11000) of the Health and Safety Code.

(C) Subdivision (f) of Section 647 of the Penal Code.

(3) "LAAM" means levoalphacetylmethadol as specified in paragraph (10) of subdivision (c) of Section 11055 of the Health and Safety Code.

(4) "Professional person" means a physician and surgeon, registered nurse, psychologist, clinical social worker, or marriage, family, and child counselor.

(b) A minor who is 12 years of age or older may consent to medical care and counseling relating to the diagnosis and treatment of a drug or alcohol related problem.

(c) The treatment plan of a minor authorized by this section shall include the involvement of the minor's parent or guardian, if appropriate, as determined by the professional person or treatment facility treating the minor. The professional person providing medical care or counseling to a minor shall state in the minor's treatment record whether and when the professional person attempted to contact the minor's parent or guardian, and whether the attempt to contact the parent or guardian was successful or unsuccessful, or the reason why, in the opinion of the professional person, it would not be appropriate to contact the minor's parent or guardian.

(d) The minor's parents or guardian are not liable for payment for any care provided to a minor pursuant to this section, except that if the minor's parent or guardian participates in a counseling program pursuant to this section, the parent or guardian is liable for the cost of the services provided to the minor and the parent or guardian.

(e) This section does not authorize a minor to receive replacement narcotic abuse treatment, in a program licensed pursuant to Article 3 (commencing with Section 11875) of Chapter 1 of Part 3 of Division 10.5 of the Health and Safety Code, without the consent of the minor's parent or guardian.

(f) It is the intent of the Legislature that the state shall respect the right of a parent or legal guardian to seek medical care and counseling for a drug- or alcohol-related problem of a minor child when the child does not consent to the medical care and counseling, and nothing in this section shall be construed to restrict or eliminate this right.

(g) Notwithstanding any other provision of law, in cases where a parent or legal guardian has sought the medical care and counseling for a drug- or alcohol-related problem of a minor child, the physician shall disclose medical information concerning such care to the minor's parents or legal guardian upon their request, even if the minor child does not consent to disclosure, without liability for such disclosure.

(Amended by Stats.1995, c. 455 (A.B.1113), § 1, eff. Sept. 5, 1995; Stats.1996, c. 656 (A.B.2883), § 1.)

Historical and Statutory Notes

1995 Legislation

The 1995 amendment, inserted subd. (a)(3), defining "LAAM"; redesignated as subd. (a)(4) former subd. (a)(3), defining "professional person"; and, in subd. (e), relating to parent or guardian consent, substituted "replacement narcotic abuse treatment" for "methadone treatment", and inserted ", in a program licensed pursuant to Article 3 (commencing with Section 11875) of Chapter 1 of Part 3 of Division 10.5 of the Health and Safety Code,".

1996 Legislation

The 1996 amendment added subds. (f) and (g), relating to legislative intent and disclosure of medical information respectively.

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The Next Best Thing:

Helping Sexually Active Teens Avoid Pregnancy

by John Hutchins

THE NATIONAL CAMPAIGN TO PREVENT TEEN PREGNANCY

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The Next Best Thing:

Helping Sexually Active Teens Avoid Pregnancy

Introduction

After nearly two decades of rising teen pregnancy rates in the United States, the 1990s saw a steady decline in teen pregnancy and birth rates in every state and among all age and racial/ethnic groups. This is great news. Fewer teens were having sex and more sexually active teens were using contraception effectively. Nevertheless, the U.S. still has the highest teen pregnancy and birth rates in the Western industrialized world — twice as high as its next competitor, Great Britain. Clearly, our nation still has a long way to go.

Our first priority should always be to encourage teens to delay sexual activity — to protect their physical health, their emotional health, and their opportunities for the future. In fact, the vast majority of parents and teens believe that school-age teens should remain abstinent.[1] However, no matter how much support we give young people to say "no," many

> "Contraception may help to protect against pregnancy and disease, but it does not protect against getting hurt by being dumped or moving too fast when you should have waited."
>
> *(Respondent to the Weekly Teen Survey on the National Campaign's website)*

will still become sexually active. And most parents and teens agree that sexually active teens should have access to contraception so that they will be protected from pregnancy and disease.[2]

It may seem too obvious to point out, but the only teens getting pregnant are those who are having sex and not using contraception effectively — or at all. And there are only three things to do about this problem: (1) convince sexually active teens to stop having sex, to have less sex, or to have fewer partners; (2) convince those kids using no contraception to use some method, any method — that is, *just do something*; and (3) convince those kids who are using relatively ineffective contraceptive methods to use more effective methods or to use the methods they've chosen more carefully. Some sexually active teens don't know enough about contraception or don't have ready access to effective methods. Education and health services can help to overcome such problems, but knowledge about and access to contraception are not enough. Motivation is the key. Avoiding pregnancy — whether by not having sex at all or by using contraception carefully — takes strong, consistent motivation. Too often, young people report that all sorts of feelings, attitudes, mistakes, and misinformation can get in the way of careful contraceptive use in particular — for instance, they say everything from "it's a hassle" to "birth control pills will make me fat" to "I got drunk."[3] Of course, staying abstinent in adolescence is equally demanding, often requiring strong motivation and resistance to popular culture and peer pressures.

In this booklet, the National Campaign highlights some of what we consider the most compelling issues in the challenge to convince sexually active teens to use contraception consistently and carefully every time. It presents a set of observations that should be considered

"I don't want to become pregnant. I am on the pill and I use a condom every time I have sex. To not use any method of contraception at all seems really stupid because you can really screw up your life that way."

(Respondent to the Weekly Teen Survey on the National Campaign's website).

carefully by any program trying to encourage sexually active teens to use contraception more effectively. This publication is by no means a comprehensive report on all the problems faced in increasing contraceptive use among sexually active teens. Instead, it is meant as a presentation of key issues for practitioners to address in their front-line work with teens. These observations are based on research presented at a roundtable meeting cosponsored by the National Campaign and Advocates for Youth and on what the National Campaign has learned from talking to parents, teens, and professionals around the nation for the past four years.* Interspersed throughout are comments from teens themselves gathered from the National Campaign's Youth Leadership Team, participants in Campaign-sponsored focus groups, and visitors to the Campaign's website (www.teenpregnancy.org).

*This report is supplemented by two new Campaign research publications that also grew out of the roundtable meeting cosponsored by the National Campaign and Advocates for Youth: (1) *Protection as Prevention: Contraception for Sexually Active Teens*, by Claire Brindis, Susan Pagliaro, and Laura Davis, which reviews in some depth current research on contraceptive use by teens, programs and services for sexually active teens, and policy issues, and (2) *Trends in Sexual Activity and Contraceptive Use Among Teens*, by Elizabeth Terry and Jennifer Manlove, which looks at the latest data from three nationally representative surveys of female and male teens (see p.26 for information about ordering these publications).

Contraceptive use among teens has improved in recent years. So why aren't we celebrating?

In the first place, most adults don't want school-age teenagers to be having sex. They also worry about the failure rates of many popular forms of contraception — condoms, for instance, have a one-year failure rate for typical use among the general population of 14 percent.[4] In addition, though, success depends how you measure it — for example, ***more teens are now using contraception the first time they have sex, but are less likely than in previous years to use contraception the most recent time they've had sex.*** In other words, there is still much to do to improve contraceptive use among sexually active teens, and we must be careful not to overstate the meaning of selected signs of progress.

In the past two decades, there was a significant increase in contraceptive use at first sex by teen males and females, primarily due to a dramatic increase in condom use. In 1982, less than one-half of females aged 15-19 used contraception at first sex and less than one-quarter used a condom. By 1995, three-quarters used some form of contraception at first sex, and 63 percent used a condom. Condom use at first sex among teen males aged 15-19 rose significantly from 55 percent in 1988 to 69 percent in 1995.[5]

However, over the same interval (1988 to 1995), there was a general *decline* in contraceptive use at most recent sex among teens with one exception: contraceptive use among black female teens remained stable. The percentage of females ages 15-19 who used any form of

contraception at last sex decreased from 77 percent in 1988 to 69 percent in 1995.[6]

No one is really sure why teens have been more motivated in recent years to use contraception the first time they have sex. Fear of AIDS and other sexually transmitted diseases, more conservative attitudes, and even some broader social and economic factors have all been offered as explanations.[7] But what then explains the decline in contraceptive use at most recent sexual intercourse? Do sexually active teens become complacent as they get older and more experienced? Are teens in long-term relationships less likely to use contraception because they trust their partners to be disease-free or to help support a child — or because condom use in a supposedly monogamous relationship seems unnecessary? Whatever the reasons behind the disparity in these patterns of contraceptive use, sexually active teens clearly need more support when three out of ten girls were totally unprotected the last time they had sex.

"I'm on the pill, but I'm really bad at taking it. It's hard to handle. You gotta turn the thing and push it and I am not into that. So, sometimes I'll forget to take it and I'll go, 'Oh, my god. It's been, like, three days!' So, I go *pop, pop, pop.*"

(Teen girl, Campaign focus group, Milwaukee)

Ambivalence is the enemy of effective, consistent contraceptive use.

Being a successful user of contraception is difficult, even for adults. It requires motivation, attention to detail, a clear understanding of consequences, and an eye on the future — qualities not always associated with adolescence. ***Between 30 and 38 percent of teens who use contraception are not consistent users.***[8] To use oral contraception successfully, for example, a young woman must visit a health care provider and obtain a prescription, pay for the visit somehow, usually have the prescription filled at a separate place, take each pill at the appropriate time, obtain refills on time, stop one cycle and start the next at the right time, interpret side effects correctly — without overreacting or underreacting — and take appropriate action to resolve problems.[9] Even "easier" contraceptive methods require planning and attention to detail. A young man must obtain a condom, carry it with him, know how to wear and use it properly, be comfortable discussing its use with his partner, have enough self-control to put it on while he is aroused, and understand when and how to remove it. And while teen males used condoms more consistently in 1995 than in 1988, even then they did not use them about one-third of the time they had sex, on average.[10] In the face of such complexities, ambivalence can interfere with what some call "contraceptive vigilance," easily leading to unintended pregnancy or STDs.

Teens express their ambivalence to consistent, effective contraceptive use in any number of ways,[11] including:

- "It's too difficult to plan ahead."
- "Condoms interfere with sexual pleasure."
- "My boyfriend doesn't want to."
- "Getting pregnant's not a big deal."
- "STDs and pregnancy won't happen to me."
- "We got caught up in the moment."

It's not that teens are *either* virgins *or* highly sexually active; many sexually experienced teens have sex only sporadically.

Traditionally, we have viewed teens as belonging to only two possible groups — (1) those who are having sex and (2) those who are not. But the situation is more complicated than that. ***There's a big difference between teens who are sexually experienced and those who are sexually active.*** Many teens have sex only occasionally — maybe two or three times a year. For example, while nearly one-half of high school students were sexually experienced (had intercourse at least once in their lives) in 1997, only about one-third described themselves as sexually active (had intercourse within the past three months).[12]

In addition, some teens who have had sex don't necessarily want to continue to do so, at least for now. In fact, eight in ten sexually experienced girls and six in ten sexually experienced boys say they wish they had waited until they were older to have sex.[13] But little attention has been paid to these ambivalent — mostly younger — teens who would be better served by an intervention that encourages them to believe that they can say "no," even if they've said "yes" before. Similarly, does it necessarily make sense to put a teenager on the pill when she may have sex once or twice a year? Perhaps other forms of contraception are more appropriate.

Teaching teens about contraception does not make them have sex.

Given that the vast majority of adults would prefer that teens not have sex in the first place, it is not surprising that many parents and teachers have wondered if giving kids information on contraception might make them more likely to become sexually active. Fortunately, years of good research provide a clear answer on this point: sex education does not increase sexual activity. In fact, in some cases, teaching teens about contraception seems to *delay* their sexual activity.[14] Because teens often harbor dangerous misconceptions about sex and contraception (for instance, that they can't get pregnant the first time), ***quality education can make a real difference.*** And teaching kids the facts about contraception is not necessarily inconsistent with a strong abstinence message, particularly if contraception is discussed within the context of marriage, for instance. Currently, approximately two-thirds of public schools offer students some formal

education about using contraception to prevent disease and pregnancy.[15]

At the same time, however, simply giving kids information about sex and contraceptive methods is not enough if we don't address their motivation to make responsible decisions and their skills to use the knowledge they have. In 1995, for example, 97 percent of teen males aged 15-19 reported having received formal sex education about AIDS prevention, 85 percent on STDs and birth control, and 75 percent on abstinence education — which was before the dramatic increase in federal funding for abstinence education in 1996.[16] Still, many of these young men had sex using no condoms or contraception at all, as noted earlier.

"My school offers a health class for grades 6 through 9, which contains a section on sex ed. It mostly just tells the anatomy of a guy and girl and birth control methods. It's somewhat educational, mostly on the birth control methods, but you can learn more from friends than you can from these classes."

(Respondent to the Weekly Teen Survey on the National Campaign's website)

Access to contraception is necessary but not sufficient.

Restricting sexually active teens from having access to contraception would be a mistake, but ***simply making contraceptive methods available to teens is not enough to motivate them to protect themselves.*** In most communities, for example, condoms are widely available to teens, yet many sexually active teens do not use them regularly. In addition, research suggests that making condoms and contraceptives available to teens in schools does not increase their sexual activity, but it also doesn't seem to markedly increase sexually active teens' use of contraception either.[17] It may well be the case that getting sexually active teens to use contraception carefully requires special support, counseling, and clinics, although even teens who get such support may still use contraception only sporadically.

The few sexuality and AIDS education programs that have improved sexually active teens' use of contraception seem to share several key characteristics. Among other things, these programs:

- provide basic, accurate information about the risks of unprotected intercourse and methods of avoiding unprotected sex.
- employ a variety of teaching methods designed to involve participants and have them personalize the information.
- are not short-term, one-time interventions.
- address social pressures related to sex.

- provide models of and practice in communication, negotiation, and refusal skills.
- select teachers and/or peers who believe in the programs and then provide them with training.[18]

Parents (and other adults) must clearly articulate their values and offer guidance to teens about responsible sexual behavior, including contraceptive use.

Teens *want* to hear from their parents about sex and responsibility — even if they don't act like it. ***Parents must step up to the plate and tell their children what they believe is right.*** But they need to listen, too, and be flexible in their responses. Lots of kids tell us that when they ask their parents questions about contraception their parents immediately *assume* they're already having sex and get angry. Sometimes kids just want information. If they think they're going to be lectured to or interrogated by their parents, they'll go elsewhere — or *nowhere* — for advice.

Here's what teens told the National Campaign they'd like parents to know:

- Talk to us honestly about love, sex, and relationships.
- Telling us not to have sex is not enough.

"No, I did not use any form of protection [the last time I had sex] ... my parents do not know that I am sexually active, and, if I told them, they would flip out and be very disappointed in me."
(Respondent to the Weekly Teen Survey on the National Campaign's website)

- Whether we're having sex or not, we need to be prepared. We need to know how to avoid pregnancy and sexually transmitted diseases.
- If we ask about sex or birth control, don't assume we are already having sex. We may just be curious, or we may want to talk to someone we trust.
- Show us what good, responsible relationships look like. If you demonstrate sharing, communication, and responsibility in your own relationships, we will be more likely to follow your example.
- We hate "The Talk" as much as you do. Instead, start talking with us about sex and responsibility when we're young, and keep the conversation going as we grow older.[19]

Remember that teens' decisions about contraception happen within relationships.

Information, access, and personal motivation aren't enough if a teen girl and her partner can't even talk about using a condom. Decisions by teens — both boys and girls — about contraceptive use happen within the contexts of

relationships, but the concept of "the couple" is often ignored in the information, counseling, and other services we provide to sexually active teens. Yet we know, for example, that one of the most powerful influences on whether a teen girl takes her oral contraceptive pill every day is the support of her partner.[20]

At the same time, ***negotiating contraceptive use within relationships is complicated, even for adults.*** Males and females may have different motivations for using contraception (i.e., HIV/STD vs. pregnancy prevention), and issues of trust and communication are critical. For example, some experts suggest that teen couples are more likely to use condoms when they first have sex to prevent against disease. However, they are less likely to do so as the relationship progresses because condoms may represent distrust of each other's fidelity — which often puts them at higher risk of pregnancy.[21]

"I'm a little embarrassed ... when I go to get condoms. But, still, I know that to myself, I'm doing this for a cause. I'm protecting myself. I'm protecting her. I'm protecting the relationship, basically."

(Teen boy, Campaign focus group, Los Angeles)

Teens should be taught about positive, respectful relationships and should see models of them at home, at school, in houses of worship, and in other community institutions. Sexually active girls and boys need support in learning about how to say "no" when they don't want to have sex and how to talk about contraception with their sexual partners when they do.

Sexually active teens are more likely to use contraception if they believe their peers do.

Overt peer pressure is just part of the story. Teens' *perceptions* of the sexual behavior of their peers have an influence on their own behavior. For instance, a teen who believes his friends are sexually active is more likely to initiate sex.[22] Peer attitudes about contraception are also important, and, in particular, ***peers can have positive effects on teen behavior.*** A sexually active girl is less likely to become pregnant if her peers are themselves at low-risk of pregnancy.[23] Teens are influenced not only by current friends. Some research suggests that teens may be more inclined to change their behavior to fit into a new crowd or form a new friendship.[24] The challenge becomes harnessing peer power to make responsible contraceptive behavior the norm among sexually active teens.

"Kids who have sex without using contraception make me mad, because they may be spreading diseases to others."
(National Campaign Youth Leadership Team member)

One popular strategy to encourage contraceptive use among sexually active teens is to develop programs led by teens and adults. Teen leaders have particular credibility with their peers on relationship issues, although teens find adult educators better at delivering fact-based information.[25]

Some sexually active teens are particularly likely *not* to use contraception and, therefore, need special attention.

Teens are not a monolithic group — 15-year-olds are quite different from 18-year-olds, for instance — and messages about contraception should reflect that fact. And special efforts should be made to reach certain groups of teens who are at much higher risk of unprotected sex:

- **The younger the teen, the less likely he or she will be to use contraception or to use it effectively.** While teen sexual activity is down (or has leveled off) among most teens, it has risen slightly among those younger than 15, the group least likely to use contraception.[26]

- **Girls who have been sexually abused or coerced or who have much older partners are much less likely to use contraception.**[27] Special efforts must be made to identify these girls and to provide them with services and support.

- **Teens are much more likely to have unplanned and unprotected sex when they are using alcohol or drugs.** Involvement with alcohol, cigarettes, and/or illicit drugs significantly increases the risk of initiating intercourse before age 16 for both boys and girls.[28] For example, teens 14 and

"I think drugs have a lot to do with it, too, because I think a lot of people's first experience is when they're intoxicated."

(Teen girl, Campaign focus group, Los Angeles)

younger who use drugs are four times likelier to have sex than those who don't.[29] And teens 15 and older who drink are seven times likelier to have sexual intercourse and twice as likely to have it with four or more partners than non-drinking teens.[30]

- **Teen mothers need extra help to avoid second pregnancies.** Teens who have already given birth are almost twice as likely as other teen girls to do so again while still teens.[31] Helping teen mothers use contraception effectively would make a big difference because more than 20 percent of all teen births are to girls who have already had at least one child.[32]

Make contraception more "teen-friendly."

Teens use different forms of contraception at different times for different reasons. For example, teen girls are more likely to use the pill at most recent sex than at first sex (23.3 percent and 8.3 percent, respectively, in 1995) and far more likely to use a condom at first sex (63.1 percent) than most recent sex (27.5 percent).[33] ***The challenge is to match the right type of contraception to the right sexually active teen at the right time.*** For instance, girls in monogamous relationships may be better served by long-term hormonal methods like the pill or Depo Provera (ideally supplemented by condoms).

In the past decade, several new contraceptive methods have become available that are particularly suited to the needs of sexually active teens, though none address the risk of sexually transmitted diseases, including HIV/AIDS. Depo Provera, "the shot" given once every three months, is an increasingly popular method for teens

"I use Depo-Provera, and I think it to be very effective. In my opinion, I think it's better than 'the pill' because you only take it once every 3 months instead of every day ... which also makes it easier not to forget. There are said to be some side effects, none of which I have seen."

(Respondent to the Weekly Teen Survey on the National Campaign's website)

because it is easy, long-lasting, and very effective. Emergency contraception, the use of a combination of oral contraceptive pills within 72 hours of unprotected intercourse, may become quite popular with teens, who often have unplanned sex. Emergency contraceptive pills reduce the risk of pregnancy after sex by at least 75 percent.[34]

We should not hold out false hope about a new method "solving" the problem of poor contraceptive use by sexually active teens. However, new types of contraception better suited to sexually active teens could make a major contribution to reducing teen pregnancy.

Conclusion

Abstinence is the best choice for teens to protect themselves from pregnancy, disease, and hurt feelings, and we should be encouraged by evidence showing that sexual activity among teens is decreasing. The fact remains, however, that about one-half of current high school students have had sex at least once, and about one-third have had sex in the past three months.[25] We can probably convince some of these teens to cease having sex — they can say "no" when they've said "yes" before. But experience and common sense tell us that many, if not most, of these teens will remain sexually active. The next best thing we can do to reduce teen pregnancy in this nation is to help motivate these teen girls and their partners to use contraception carefully each and every time they have sex.

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- ***Protection as Prevention: Contraception for Sexually Active Teens***, by Claire Brindis, Susan Pagliaro, and Laura Davis, which reviews in some depth current research on contraceptive use by teens, programs and services for sexually active teens, and policy issues.

- ***Trends in Sexual Activity and Contraceptive Use Among Teens***, by Elizabeth Terry and Jennifer Manlove, which looks at the latest data from three nationally representative surveys of female and male teens.

To order these publications, contact:
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THE
NATIONAL
CAMPAIGN TO
PREVENT TEEN PREGNANCY

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The mission of the National Campaign to Prevent Teen Pregnancy is to improve the life prospects of this generation and the next — and, in particular, to reduce child poverty — by influencing cultural values and building a more effective grassroots movement.

The Campaign's goal is to reduce the teen pregnancy rate by one-third between 1996 and 2005.

Youth Development Reader. California Department of Health Services. Leadership Conference, April 2001.

YOUTH DEVELOPMENT READER

for the State of California
Department of Health Services

Youth Development & Pregnancy Prevention: Problem Free & Fully Prepared

LEADERSHIP CONFERENCE, APRIL 2001

Youth Leadership Institute

Youth Development Approaches

Focus on Youth Needs & Competencies *Academy for Educational Development* *Karen J. Pittman:* (1991)	*Focus on Developmental Assets, Search Institute* *Peter Benson, President:* (1997)	*Focus on Supports & Opportunities* *Institute for Research & Reform in Education* *James P. Connell & Michelle Gambone:* (1998)	*Social Development Strategies: Risks & Protective Factors* *Bonnie Benard, Hawkins & Catalano:* (1990)	*Youth Leadership Institute* *Maureen A. Sedonaen:* (1999)
Basic Needs: A sense of... • Safety & Structure • Belonging & Group Membership • Self-Worth & Contributing • Independence & Control of One's Life • Closeness in Relationships • Competence & Mastery **Competencies for Success** • Health & Physical Competence • Personal & Social Competence • Cognitive & Creative Competence • Vocational Competence • Citizenship Competence **More Adolescent Needs:** • Diverse Opportunities & Expectations • Need to Explore Self & Environment • Need for Physical Activity • Need for Supervision	**"Framework of 40 Developmental Assets"** **External Assets:** • Support • Empowerment • Boundaries & Expectation • Constructive Use of Time **Internal Assets:** • Commitment to Learning • Positive Values • Social Competence • Positive Identity	**"Theory of Change for Community-Based Youth Initiatives"** **Support & Opportunities for Youth:** • Relationship-Building • Youth Participation • Community-Building **Youth Development Outcomes** • Learning to be Productive • Learning to Navigate • Learning to Connect **Long Term Societal Outcomes** • Economically Self-Sufficient • Healthy Family & Social Relationships • Contributor to Community • Healthy Self-Identity ***Utilized in Community Network for Youth Development in Bay Area, CA***	**Risks & Protective Factors** Protective Factors, Traits & Conditions **Strong Positive Social Bonds:** • Social Bonding Positive Responses • Social Competence Social Skills • Personal Competence Self Efficacy, Identity **Resilient Person** • Positive Outlook • Responsive & Flexible • Satisfactory Involvement	**Provides:** • Supports • Opportunities • Skills **Five Core Values:** • Youth Adult Partnerships • Innovation • Advocacy & Leadership • Learning & Teaching • Community & Relationship Building
OUTCOME NOTES				
Serves as a useful tool for shaping program design. For example, how does the program provide youth with a sense of belonging? Program outcomes can be direct youth outcomes	Provides a "snapshot" of the "health" of a community	Community based program outcomes: program <u>only</u> accountable for high quality supports and opportunities	Knowledge and consciousness about risks & protective factors to influence program design and create measurable outcome objectives	Different programs activities can be linked to specific outcomes of each model

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TEN KEY ISSUES IN TEEN PREGNANCY PREVENTION

1. **Accessible/ confidential/ affordable reproductive health services** – providing adolescent health and reproductive health services during hours and days that are convenient for adolescents to get to staffed by teen friendly/sensitive adults and peers.

2. **Comprehensive sexuality education** – school based, age appropriate, medically accurate, and up-to-date information about reproductive health. It includes developmental stages of adolescent sexuality, anatomy/physiology, and information about setting personal boundaries, discussions about self-esteem and discussions of health adolescent sexuality.

3. **Males included** – the role of males (adolescents and adults) must be included.

4. **Promote consistent and correct use of contraception** – education and outreach efforts must encourage the consistent and correct use of contraception (over-the-counter and prescribed birth control options)

5. **Sexuality education and STI/HIV/AIDS prevention programs** – community based programs that discuss not only abstinence but also condoms and other methods of contraception,

6. **Abstinence-only**- These are programs that focus on the importance of abstinence from sexual intercourse, typically until marriage. Either these programs do not discuss contraception or they briefly discuss the failure of contraceptives to provide a complete protection against pregnancy and sexually transmitted infections

7. **Youth development programs** – programs that integrate sexuality with general skill-building activities, future planning, and even tutoring and job seeking skills.

8. **Media** – what are the messages and the messengers that influence adolescent sexual behaviors and choices

9. **Adults/Parents** - Parent/adult – child discussions and conversations that are open and respectful regarding adolescent sexuality and teen pregnancy prevention issues.

10. **School-based health centers** – school-based health centers can provide affordable primary health care services to students. Some also dispense contraceptives or prescriptions.

* Topics are not ranked in order of importance. This is not an all inclusive list.

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complement and contrast with the various experiences they have in their families, schools, peer groups, work environments, neighborhoods, and communities.

The context in which youth development happens is critical, and because families are burdened with ever increasing stresses, our job as youth organizations is becoming increasingly important. The role we can play in delivering services to young people and building the capacity of youth and adults to impact their surroundings becomes part and parcel of the work of families. We know that an abundance of options and alternative settings in a community are critical to assisting and supporting youth as they navigate toward a meaningful future. But the "new order" of collaboration and program delivery calls us to remember in a conscious and informed way that families, however they are defined, cannot be discounted from our equation. This is important: we need to resist the protective urge to silo ourselves into programmatic boxes of expertise and embrace the chances we have to create and maintain appropriate settings and climates for all young people. Forgetting about families endangers our ability to offer them what they really need and what will really assist them in their development: supports, opportunities, and skills. Keeping youth and families in the forefront of our minds will ensure that the program we create are really *for them*, and not for the sake of keeping our programs and organizations going. Just as families are diverse and variant, then, the settings in which young people develop need to be just as diverse, with a variety of traditional and non-traditional opportunities available. This is just one of the critical aspects of good settings.

So what makes a good setting? There are several key characteristics that are critical to positive settings:

- *Safety*: Are young people physically, emotionally, and culturally safe in a program? Is safety a priority?
- *Variety*: Is the program providing the same thing that the Teen Center up the street is providing? In the community as a whole, is there enough variety of choices – of activities, of environments, of levels of involvement – for young people to pick from?
- *Consistency*: Is the staff stable? Do young people have consitent relationships over time with the adults in the program? Are policies enforced uniformly? Can young people come to have expectations of the program that will be met the majority of the time?
- *Opportunities*: Does the program provide youth with meaningful opportunities to do things they could not otherwise do? Does the program involve young people actively, as more than recipients?
- *Diversity*: Is the program diverse?

Key Characteristics of Positive Settings:

- *Safety*
- *Variety*
- *Consistency*
- *Opportunities*
- *Diversity*

Making A Shift: Programs and Policies

Our goal in talking about the "settings" in which young people experience the world is to shift the focus of the public discourse from youth "problems" – and the prevention and treatment of those problems – to capacity building that prepares young people to experience success and contribute meaningfully to society. Making this shift will not be easy. We must be bold and strategic on a national, statewide, and local level to bring this message to all of the organizations and institutes that can impact the lives of young people. We must build a network of organizations who are promoting positive youth development and who have the skill and capacity to share their expertise. We must promote and expand proven best practices and make these available across communities to ensure outcomes that lead to productive, involved, and caring citizens. If we want young people to contribute to our society in a meaningful and sustained manner, then we need to be deliberate about

Organizational practices: In order to increase the number of quality people, places, and possibilities available to young people we need to find ways to examine organizational practices. This will help us first to assess whether or not programs are effective and second to share best practices and make course corrections when necessary. Just as youth grow up in families not programs, programs grow inside organizations and institutions; organizational best practices ensure healthy, stable, and successful programs. Our strategies for evaluation and program accountability must be firmly grounded in youth development theory. As we examine and design tools to assess this it will be important to acknowledge two significant realities: (1) programs have varying levels of expertise and capacity to engage in self-assessment and evaluation, and (2) programs have varying levels of understanding and commitment to positive youth development principles.

A recent study conducted by Social Policy Research Associates (SPR) highlighted several challenges related to designing accountable youth development programs, including[2]:

- *Adolescent development is a process that occurs over a long period of time, as a result of multiple influences.* Youth development results from multiple influences, and a variety of settings (e.g. family, peers, school and community, etc.) over a sustained period of time. Therefore, no single experience can produce youth outcomes sometimes cited by researchers (e.g.gains in self-concept, ability to navigate difficult situations). Unless a program or initiative is extremely intensive, it would be inappropriate (and expensive) to hold a program *solely* accountable for a particular developmental outcome. Instead, developmental outcomes are the sum total of the various settings and influences that touch a young person.

The presence of these challenges and others has created a growing emphasis in the youth development field on developing program

those expectations, and we need to be aware that keeping them from harm is only half the work:

> "The public health approach to prevention dictates treating those with the problem, modifying the attitudes and habits of those whose behaviors place them at risk of the problem, and educating those not yet engaged n risky behaviors. But prevention along is not enough. Problem-free is not fully prepared. We need to define what we want youth to do as forcefully as we articulate what we do not want."[1]

The prevention model contributes to the tendency of youth programs to "own" young people. Owning youth participants allows us to claim credit when they are "saved" or prevented from harm. But the paradigm shift must happen on a policy level, so that prevention alone is recognized as not enough, as well as on a community-based level. Community-based programs must recognize the damage we do – to young people and ourselves – if we continue to regard youth as "ours" and "theirs." If the turf wars that rage between community-based organizations continue, we cannot expect to be successful in a collaborative and comprehensive effort to help young people be both problem free and fully prepared. We cannot expect to prevent negative outcomes for youth *or* to show the powerful impact we are having in their lives.

What can we put in place so that we **can** anticipate success?

Accountability. We need to hold programs accountable in a reasonable way for the settings they create for youth. What is happening in those settings? What experiences do young people have there? What skills can they attain? What support is provided to them? Just as youth grow up in families not programs, programs grow inside organizations and institutions.

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[1] Pittman, K. and M. Irby *Preventing Problems or Promoting Development: Competing Priorities or Inseparable Goals?* Center for Youth Development and Policy Research, Academy for Educational Development. 1995

accountability tools that examine the experiences and skill development young people have interacting with a particular program.

As we build tools for youth development evaluation, a consideration of the settings where youth development occurs is tantamount. This allows us to look across disciplines and find the commonalities and differences in program design that will give us a holistic and accurate picture of our community's climate for young people. The infusion of youth development frameworks allows us to (1) get out of our "program" or "issue" boxes and examine the negative behaviors we are attempting to eradicate, and (2) account for the positive supports, opportunities and skills a young person has attained in the broader community.

This will allow for the development of settings that provide a comprehensive youth development infrastructure, which in turn will increase public will to support positive development for all youth. This accountability will then bring us to a framework of positive youth development settings which embrace the following principles:

- *Problem-free is not fully prepared:* Preventing negative, high-risk behaviors is not enough. Our expectations for young people must be high and clear. The presence of positive outcomes should be defined and monitored as carefully as the absence of negative behaviors.
- *Academic skills are not enough:* Young people are engaged in the development of a full range of competencies – personal, social, vocational, health, civic, etc. Focusing on academic competence alone result in unbalanced discussions of resource allocation across systems and of teaching and learning methodologies within systems.
- *Competence, in and of itself, is not enough:* Skill building is best achieved when young people are confident of their abilities, contacts and resources and are called upon by their communities to use their skills. Meeting the basic needs for safety, structure, relationships, membership, independence and contribution is critical to the development of competencies. Attention must be paid to both the content of learning and the contexts in which the learning occurs.

THE GOOD NEWS: The right setting will by definition be about *preparing* young people for more than avoiding problems. And because variety of experiences is a priority, young people can taste success in ways other than academic. The opportunities and the environment will give young people the freedom to learn what they are capable of.

Recommended Standards of Practice for Positive Youth Development

In choosing to embrace a youth development approach to your practice, it is essential that as an organization you develop, plan and evaluate impact assessing your "process outcomes" or "standards of practice". The program and community stakeholders " must agree on a set of outcomes that are important, achievable, and measurable". (Schorr, Common Purpose,1997,p122) These outcomes might include process outcomes-standards of practice that articulate what types of **experiences** we want young people to have through youth development based programming, as well a participant outcomes-how young people will **change** as a result of participation at your program. The Organization must clarify which standards of practice all programs (treatment and prevention) should be held accountable for, and potentially, what types of youth outcomes we can realistically be expected to achieve. In considering the latter, programs should identify the youth outcomes over which they have some measure of control. Here is a sample of some potential organizational outcomes:

Young People:

1) will experience a safe environment

Key Indicators

- emotional safety: e.g. Everyone is expected to treat others with respect
- cultural competency: e.g. Youth from different ethnicities and cultures feel respected and affirmed.
- physical safety: e.g. Youth are able to experience an alcohol, tobacco and drug free environment, and youth are safe from physical harm and violence will engaged in YLI activities

2) will have opportunities for involvement and connection to community and school

Key Indicators

- Youth have opportunities to contribute to their community
- Youth have knowledge of their community, what's available and accessible to them,

3) will have opportunities for leadership and advocacy

Key Indicators

- Youth give significant input into action and event planning
- Youth participate meaningfully in governance and policy-making for their chapter, council, commission or board structure.

4) will have opportunities to engage in meaningful skill building activities that are designed to capture the interest and participation of young people.

Key Indicators

- Youth learn and practice new skills, such as public speaking, critical thinking or analytical skills, community organizing, and action planning
- Skill building activities are designed based upon what young people are interested in.

5) will have opportunities for caring and meaningful relationships among youth and with adults

Key Indicators

- Guidance and Practical Support: e.g. Youth are able to go to staff for guidance, to obtain resource and referral information, or for "navigational" advice.
- Emotional support: e.g. Adult staff pay attention to what's going on in the lives of youth members
- Adult Knowledge of Youth: e.g. Youth feel that adults know them well and that their relationships with adults are consistent over time.
- peer knowledge of youth: e.g. Youth have opportunities to get to know their peers

The underpinning of successful positive Youth Development based programs are strong, clear and consistent Organizational Practices. Organizational Practices serve as a barometer for long term, sustainable achievements by programs over time.

Organizational Practices

Organizational practices are those things that a program or organization does in order to ensure the successful achievement of its standards of practice
(also known as "process outcomes"and"supports &opportunities.")

YLI's organizational practices are

1. ensure continuity and consistency of adults and other youth
2. establish clear rules and high expections
3. create community partnerships that support youth in the program
4. establish ways for program activities to be youth-driven and youth-led
5. demonstrate cultural sensibility
6. support and train adult staff on a regular basis to work effectively with youth
7. establish clearly defined, research-based goals and ways to measure effectiveness in achieving those goals
8. evaluate programs periodically to assess progress and to improve and strengthen them effectively

Organizational Practices have a direct impact on young people's experience of YLI. A program committed to these organizational practices has the capacity to provide youth with supports and opportunities (standards of practice, process outcomes).

Standards of Practice: Youth will experience;

1. experience a safe environment free harmful behavior
2. have opportunities for involvement and connection to community and school
3. have opportunities for leadership and advocacy
4. have opportunities for meaningful decision-making
5. have opportunities for caring and meaningful relationships among youth and with adults

These standards of practice are the things that YLI can be held directly accountable for because they refer to how a young person experiences YLI.

These standards of practice will ***indirectly*** contribute to a variety of developmental youth outcomes.

Developmental Youth Outcomes

Also called "participant outcomes", these are things like resiliency traits, positive self-concept, and self-determination. However, programs cannot be held solely accountable for these outcomes, since a young person's development occurs in an on-going fashion, influenced and shaped by all of their interactions and experiences, not only those associated with a particular program.

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Preventing Problems or Promoting Development: Competing Priorities or Inseparable Goals?

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International Youth Foundation
September 1996

Based upon An Advocate's Guide to Youth Development
By Pittman & Irby
Center for Youth Development & Policy Research
Academy for Educational Development
1995

Preventing Problems or Promoting Development:

Competing Priorities or Inseparable Goals?

Concerns about youth problems and youth outcomes continue to grow, but far too few questions are asked about adult and community responsibility for intervention, prevention, or development. Perhaps this is because youth problem prevention, youth development, and community development are seen as competing priorities rather than inseparable goals.

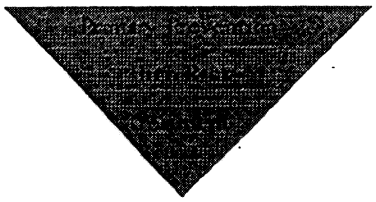
In talking about prevention over the past decade, we have applied a basic public health model that suggests we have to treat those who have the problem or disease, modify the attitudes and habits of those at risk of contracting the problem because of their behavior, and educate those not yet engaged. Cancer treatments, smoking cessation, and anti-smoking campaigns reflect this three-tiered public health response to lung cancer. The public health model is a triage approach that says we have to do those three things and that just doing one or two is not enough.

The public health approach to prevention dictates treating those with the problem, modifying the attitudes and habits of those whose behaviors place them at risk of the problem, and educating those not yet engaged in risky-behaviors.

[Figure 1]

Figure1

Addressing Youth Problems is Critical...



The model has merit and, beginning with substance abuse, has been heavily applied to the array of youth problems. While it has brought legitimacy to the idea of prevention, it is not enough. When applied to more complex individual issues such as violence, unemployment, early pregnancy, it limits strategies because of its focus. When we talk about prevention, we are talking in terms of problems. But no

matter how early we commit to addressing them, there is something fundamentally limiting about having everything defined by a problem. In the final analysis we do not assess people in terms of problems (or lack thereof), but potential.

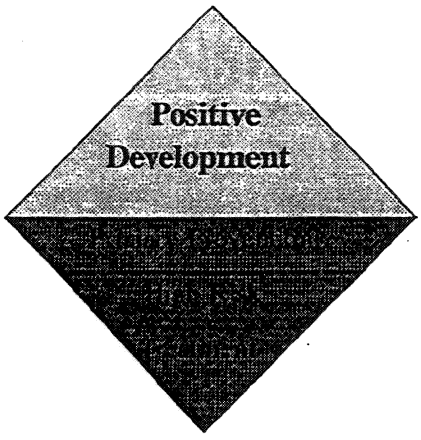
Case in point. If I introduced an employer to a young person I worked with by saying, 'Here's Katib. He's not a drug user. He's not in a gang. He's not a dropout. He's not a teen father. Please hire him.' the employer would respond, 'That's great. But what does he know, what can he do?' If we cannot define -- and do not give young people ample opportunities to define -- what skills, values, attitudes, knowledge, and commitments we want with as much force as we can define what we do not want, we will fail. Prevention is an inadequate goal. Problem-free is not fully prepared.

But prevention alone is not enough. Problem-free is not fully prepared. We need to define what we want youth to do as forcefully as we articulate what we do not want.

[Figure 2]

Figure 2

But, Problem Free is Not Fully Prepared



Developing Positive Youth Outcomes: The Glass Half-Full

What are the goals we as a society have for young people? Beyond the specific goal of staying out of trouble, the policy literature usually contains broad statements about how we want young people to be good citizens, good neighbors, good workers, and good parents. The academic and programmatic literatures usually push farther, articulating general lists of competencies that we want for young people. These go beyond academic competence. Numerous commissions and organizations, including the Carnegie Council on Adolescent Development, define a generic set of competencies that go beyond academic or cognitive competence to include vocational, physical, emotional, civic, social and cultural competence.

The problem is that we have not established developmental benchmarks or defined the steps needed to acquire this fuller range of competencies. As end goals, high school and post-secondary education and employment are the primary measures of "developmental success." Consequently, the educational field is littered with benchmarks -- individual benchmarks such as being on grade, passing courses, achievement tests; national benchmarks such as the National Assessment of Educational Progress -- and vocational experts and the business community are developing indicators of vocational competence or readiness. But definitions of competence in the other areas are blurry at best. In these areas, success is still largely defined as lack of problems (e.g., pregnancy, violent or delinquent behavior, gang involvement, open racism). Clearly a key task in linking prevention with development is broadening our definition of desired and expected competencies beyond academic skills and employment. Shifting goals from gang prevention to civic involvement, for example, requires a fairly dramatic shift in strategies.

The competencies that we want for young people go well beyond academics to include social, physical, civic, vocational and cultural competence.

[Figure 3]

Figure 3

Desirable Youth Outcomes

Having a sense of:

CONFIDENCE

Self-Worth
The ability to contribute, and to perceive one's contributions as meaningful.

Mastery & Future
Awareness of one's progress in life and projecting into future.

CHARACTER

Responsibility & Autonomy
Accountability for one's conduct and obligations. Independence and control over one's life.

Spirituality
Connectedness to principles surrounding families, cultural groups, communities and higher deities. An awareness of one's own personality or individuality.

CONNECTION

Safety & Structure
Being provided adequate food, clothing, shelter, and security, including protection from hurt, injury, or loss.

Membership & Belonging
Being a participating member of a community. Being intimately involved in at least one lasting relationship with another person.

Having the ability & motivation:

COMPETENCE

Civic & Social
To work collaboratively with others for the larger good, and to sustain caring friendships and relationships with others.

Cultural
To respect and affirmatively respond to differences among groups and individuals of diverse backgrounds, interests, and traditions.

Physical Health
To act in ways that best ensure current and future physical health, for self and others.

Emotional Health
To respond affirmatively and to cope with positive and adverse situations, to reflect on one's emotions and surroundings, and to engage in leisure and fun.

Intellectual
To learn in school and in other settings, to gain the basic knowledge needed to graduate high school, to use critical thinking, creative, problem-solving and expressive skills, and to conduct independent study.

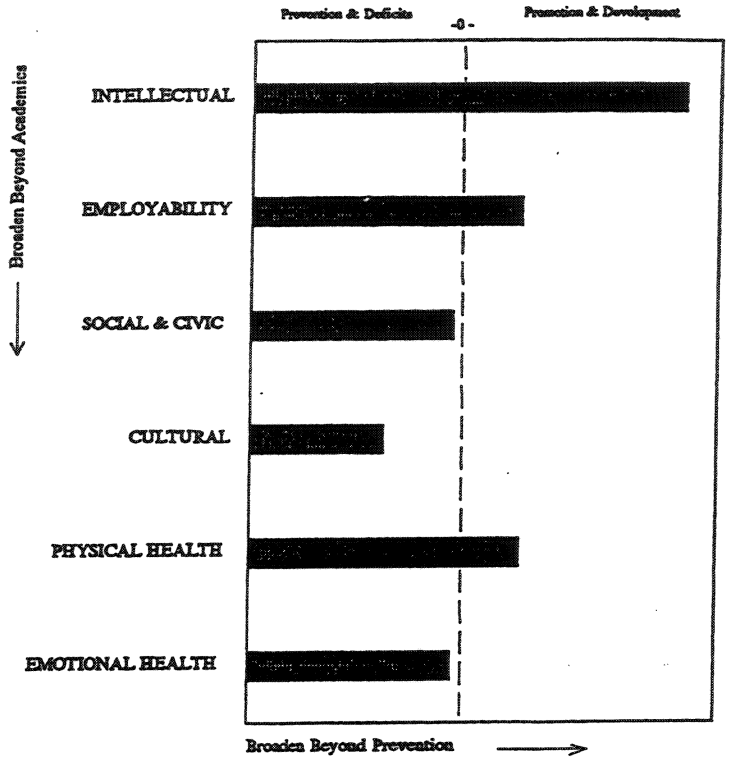
Employability
To gain the functional and organizational skills necessary for employment, including an understanding of careers and options and the steps necessary to reach goals.

But this is only half the challenge. Paralleling the broadening of our definition of expected competencies has to be an acceptance of the importance of a second set of outcomes -- those that allow young people to be not only competent, but connected, caring and committed. In addition to skills, young people must have a solid sense of safety and structure, membership and belonging, mastery and sense of purpose, responsibility and self-worth.

But we have not established developmental benchmarks for these competencies and have not invested in ensuring that youth have what they need to develop them. [Figure 4]

Figure 4

Comparing Current Indicators Across Competencies



These basic needs are not peculiar to youth. Safety, structure, belonging, purpose -- these are the essential elements of Maslow's basic needs hierarchy that we all learned in Psychology 101. Defining youth outcomes solely in terms of the competencies -- the skills, behaviors, knowledge -- that we want them to have and not in terms of the broader psychosocial components that make them confident young men and women limits our strategies and undermines our chances of success. It is foolish to continue to ignore the fundamental interconnection between the development of confidence and the development and application of competence.

Supports, Opportunities, and Services: The Ingredients for Youth Development

If these are the outcomes we want to achieve, what are the basic inputs or raw resources that young people need? The literature on factors influencing youth development suggests seven key inputs. Places are important. Young people need a stable place which is theirs and where they feel safe. That place can -- and should -- be home. It can also be a religious organization, a school, a community center. Young people need access to basic care and services that are appropriate, affordable, and, if necessary, confidential. Essential also, are high quality instruction and training. Places, services, instruction, frame the resources that families and communities offer youth. But it is the supports and opportunities offered in these settings that are critical. Young people have to have opportunities to develop sustained, caring relationships and social and strategic networks. They need challenging experiences that are appropriate, diverse, and sufficiently intense. They need opportunities for real participation and involvement in the full range of community life — not just picking up trash on Saturdays. All young people, affluent or low-income, above grade or out-of school, need a mix of services, supports and opportunities in order to stay engaged. Services alone will not draw youth in from the streets, not because we cannot match the money, but because we cannot match the intensity of supports (e.g. protection, belonging) and opportunities. This list of inputs is very simple and sensible. There are two reasons, however, that we do not use it to guide decisions about policy. First, we ignore what is known about human motivation and development, insisting that youth must be "fixed" before they can be developed.

Young people need places, services, instruction. But they also need supports -- relationships and networks that provide nurturing, standards, and guidance -- and opportunities for trying new roles, mastering challenges, and contributing to family and community. [Figures 5]

Figure 5

Community Support Inputs that Promote Youth Development

1. Stable Places.
2. Basic Care and Services
3. Healthy Relationships with Peers and Adults.
4. High Expectations and Standards.
5. Role Model, Resources, and Networks.
6. Challenging Experiences and Opportunities to Participate and Contribute.
7. High Quality Instruction and Training.

Second, we focus too heavily on structuring services to solve problems and too little on strengthening supports and opportunities to increase potential.

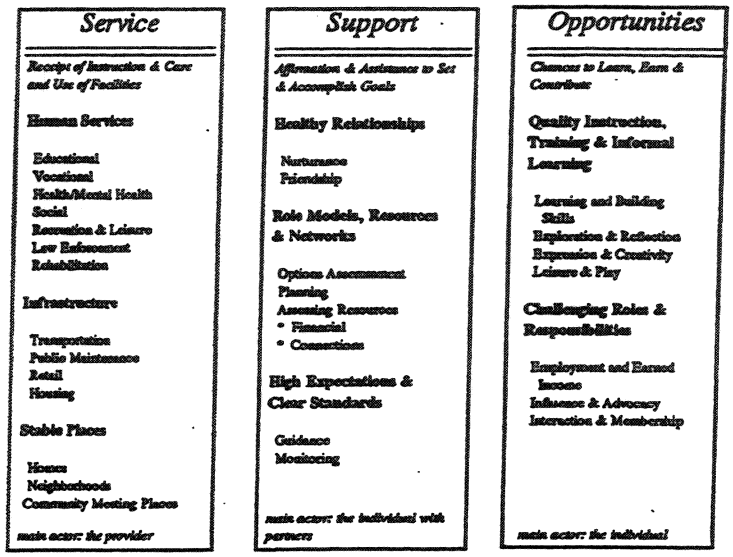
Process: The Dynamics of Youth Development

In thinking about vulnerable, disadvantaged, or marginalized youth (or families or communities), the "fix-problems-first" assumption is antithetical to the dynamic of development. While problems must be addressed, it is a commitment to development -- the offering of relationships, networks, challenges, opportunities to contribute -- that motivates growth and change.

Gangs offer young people protection, structure, personal ties, and real challenges. We have to offer services, supports and opportunities to compete with the streets.

[Figure 6]

Figure 6

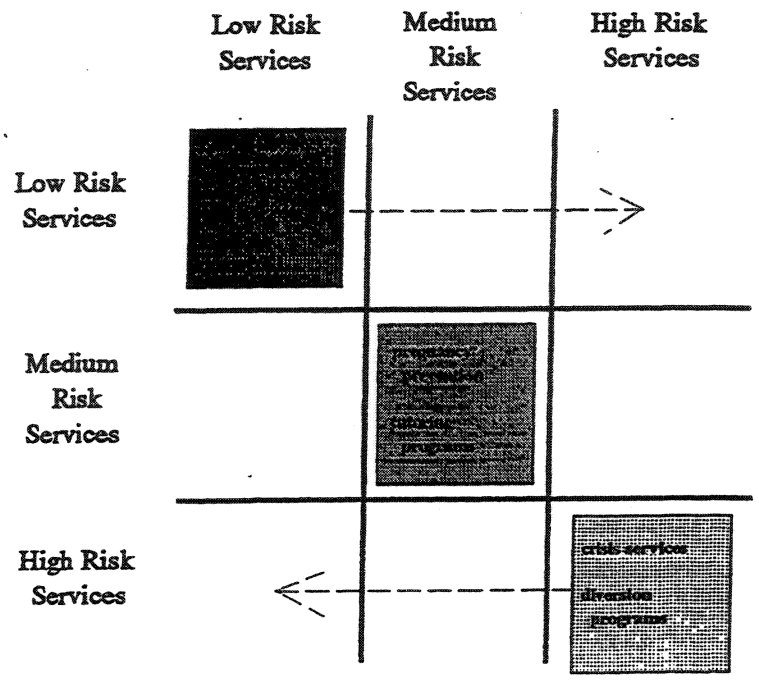


No one is inspired when they walk in the door and are greeted with 'We're here to fix you.' But that is what we do. We do it to young people. We do it to families. We do it to communities. We assume that if young people, or families, have problems, that these have to be fixed before there is any interest or justification for exploring opportunities for development. "Low-risk" youth in "low-risk" communities get orchestras, summer camps, accelerated learning opportunities. "High-risk" youth in "high-risk" communities get substance abuse prevention counseling and diversion programs. But until there is a challenge, there is no reason that any person, young or old, is going to be sufficiently engaged to change.

The assumption that youth must be fixed before they can be developed runs counter to what is known about human motivation and adolescent development. All youth need to be challenged as well as cared for.

[Figure 7]

Figure 7



There has been an extensive amount of research done on adolescent development and little of it has been put into daily practice. What is known?

Development is uneven. This is the most obvious feature of the adolescent development process. Thirteen year old, for example, vary greatly in their physical, emotional, social and cognitive development. This variance is not only among 13 year old as a group, but also within any individual 13 year old.

- It is complex. Try as we may, it is difficult to affect one aspect of development (e.g. cognitive) without acknowledging if not addressing the others.
- It requires engagement. It is fostered through relationships, influenced by environments and triggered by participation. Services can be delivered without engagement, but development only occurs when young people are engaged.

High quality services are essential, but development does not occur without engagement. Adolescent development is uneven, ongoing, complex and profoundly influenced by the quality of the relationships, environments, and commitments in which young people are involved.

[Figure 8]

· It is both ongoing and resilient. We cannot just intervene at one point and assume all will be fine; neither can we with good conscience not intervene, assuming that it is too late.

Figure 8

The Development Process: Key Characteristics

Youth Development is:

Ongoing	spanning the periods of early adolescence (9-13), middle adolescence (13-17) late adolescence (17-21), and young adulthood (21-).
Uneven	varying among youth of the same age and within a given individual.
Complex	spanning five growth areas: physical, cognitive, social, emotional, and moral.
Influenced by Environment	both the physical attributes (safety, appearance) and the quality and quantity of key services, supports, and opportunities.
Mediated thru Relationships	with parents, family members, neighbors, peers, teachers, coaches, employers, youth workers, and other professionals.
Triggered by Participation	opportunities for involvement, contribution, learning.

There is a sizable body of academic and practical knowledge to back up the basic argument that services alone do not ensure development. The research on resilient children and youth, for example, suggests that three factors contribute to these children's ability to "beat the odds": a strong relationship with a caring adult, high expectations, and opportunities for meaningful participation. In addition, these children have a sense of connectedness and confidence that allows them to develop competencies.

Research on resilient youth – those who have "beaten the odds" – show that somewhere in their lives they have a caring adult, high expectations, and opportunities for meaningful participation.

[Figure 9]

Figure 9

Characteristics of Resilient Youth

- Good Social Skills
- Problem Solving Skills
- Sense of Independence
- Sense of Purpose

Characteristics of Supportive Communities

- Caring Adults
- High Expectations
- Opportunity for Participation

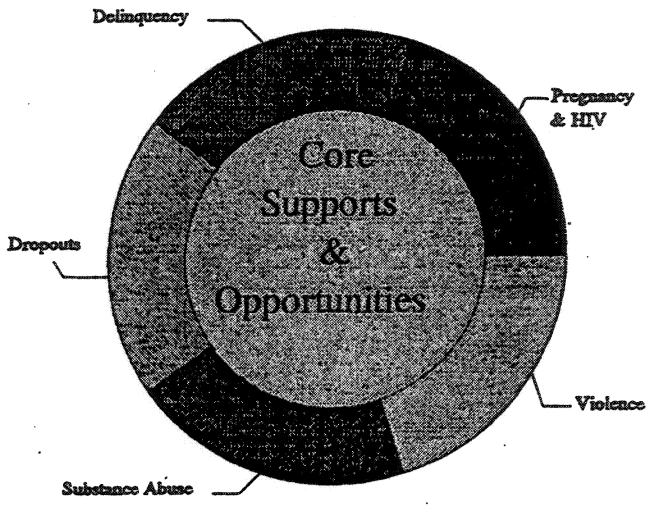
Most telling, however, is the research on effective prevention programs. Because funding dictates services, we have woven a crazy quilt of problem-specific interventions that often operate independently and inefficiently. We have reduced the challenge of youth development to a series of problems to be solved, leaving the core inputs for development – supports and opportunities – to be addressed in a catch-as-catch-can fashion. Substance abuse prevention, pregnancy prevention, dropout prevention, and violence prevention programs all have separate funding and separate evaluation measures. But the core of what is offered in these programs is the same: opportunities for membership, social skill building, participation, clear norms, adult-youth relationships, and relevant information and services.

Substance abuse prevention, pregnancy prevention, dropout prevention, and violence prevention programs have separate funding and separate evaluation measures.

[Figure 10]

Figure 10

Common Core of Prevention Strategies



But the core of what is offered in these programs is the same: opportunities for membership, social skill-building, participation, clear norms, adult-youth relationships, and relevant information and services. [Figure 11]

Figure 11
Common Themes in Prevention Programs

Skill Building	Building social skills, problem-solving skills and communication skills;
Participation	engaging youth through offering real opportunities for participation (e.g. youth led discussions, real choices), leadership (e.g. youth as peer counselors, tutors, contributors)
Norms and Expectations	establishing new norms and expectations for behavior that are sanctioned by the group
Adult-Youth Relationships	establishing deeper and different ways for youth and adults to relate through the creation of different structures for interaction and specific training for adult leaders
Information and Services	providing problem-specific information and services or access to services

Communities: The Context for Development

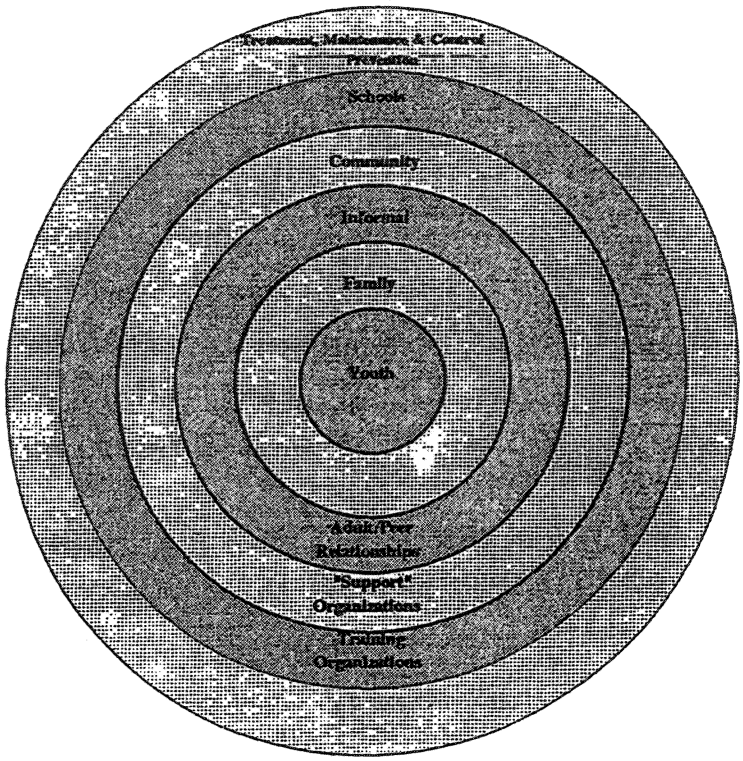
Programs and organizations can have an enormous impact on youths' lives, but this impact is either amplified or dampened by the quality and congruence of what else is going on in young people's families, peer groups, and neighborhoods. There are, as always, young people who "beat the odds", but it is the differences in family and community that determine the odds.

Young people grow up in a set of imbedded networks. The complexity and unevenness of adolescent development and the need for constancy in relationships, environments and engagement means that those best positioned to influence development are the "natural actors" in youths' lives -- family, peers, neighbors, and community institutions.

Programs and interventions are needed. But the long-term task is to help families, neighbors, and communities nurture, support, and demand excellence from their youth. This requires sustained investments in community institutions, associations, and infrastructures. [Figure 12]

Figure 12

Supportive Community:
A Youth-Centered Perspective



In the ideal, children and youth have their broadest, strongest, and most permanent connections to family. Their development is enhanced when they are further supported by peers and neighbors; attached to an array of community organizations; engaged in school; exposed to work; and connected, as needed, with professionals that provide or broker for basic services such as health care, housing, protection and social service.

Any and all of these networks can provide the key inputs needed. The list of inputs offered is intentionally place/provider-generic. It states what is needed, but does not specify who supplies it or where it is found. In some communities, the networks are well equipped and well connected enough that a young person can get all that is needed naturally from family, neighbors, and an assortment of informal or individually negotiated experiences. In other communities, because these inputs are not available in sufficient quantity and quality, essential services, opportunities, and supports may need to be created. The critical question is how.

Strategies: Linking Prevention and Development

1. Broaden the goals. When we talk about problems, we end up talking about programs and services and we think about interventions in discrete blocks of time. When we talk about development, we end up talking about supports and opportunities, and recognize the importance of continuity, challenge, choice. Applying what we know about youth development suggests some obvious strategies. We have to broaden the goals. Not just school and jobs, but health, social, and civic competencies. Not just competencies, but the confidence and connectedness needed to use them well.

2. Support the process. We need to articulate better the supports and interventions needed to achieve those goals. And we have to acknowledge and address the developmental and environmental contexts that affect outcomes. These are lofty statements of what we should do. They need to be counter-balanced with some more practical statements about programmatic changes that would signal a shift from problem-prevention to youth development.

3. Target without trapping. Resources need to be targeted to maximize impact and to match the needs of young people with the resources available. But targeting often involves outside judgements not only about who needs resources but what resources are most needed.

4. Evaluate the whole. Two things happen when we focus too heavily on a single problem. We weaken the possibilities of both documenting impact (by tracking only a narrow set of outcomes) and having impact (by focusing to narrowly on a specific set of inputs). Many programs argue that they are comprehensive in approach and broad in services; all should be evaluated against some basic outcomes that reflect the full set of competencies and connections desired. Anyone who has worked intensely on any discrete youth problem (e.g., teen pregnancy) learns quickly that the problem is

intertwined with education, with opportunity structures, with family connection and support, and with a range of developmental issues which cannot be ignored if any intervention is to be successful.

5. Hold institutions accountable for improving family and community outcomes. And because of the way we expect them to run and evaluate their efforts, there is a strong tendency to reach over school, community organizations, neighbors, families, and try to do something directly to the young person. And what we know is that as soon as the intervention stops, things revert. And so I would offer a very simple rule that we try in program development, which is to suggest that the responsibility of one ring is to assist and support the next ring in. Unless by law you have some formal responsibility for intervening directly, why not work with the next ring in? Why do we not have health, social services, and juvenile justice working with the schools to do early identification of who needs help and with follow-up work in the school setting? Why aren't schools working with community organizations to help work with parents, find parents, develop homework assistance techniques and understand better what's going on in the community? Why aren't community organizations helping parents and neighbors be the role models, resources, and key informal supports that are so critically needed? And finally, why aren't parents and neighbors insisting that young people play a more active role in their communities?

6. Strengthen the inner rings. Young people grow up in families. They have peers and neighbors around them — informal support groups. Their neighborhoods are full, hopefully, of community organizations that are there permanently in their lives: religious organizations, community centers, recreation departments, libraries, youth centers, etc. They have schools and later training institutions that are there. In addition, there are treatment and health and social service organizations that should not be part of their daily lives. From the perspective of development, we should be investing in families and neighbors and communities. When we have a

problem approach, who gets the money? The institutions on the outside are given the money and the responsibility to do a job that needs to happen close to home.

7. Invest in core supports. See community organizations as catalysts as well as service providers. Programs (i.e., structured offerings of services, supports, and opportunities delivered to achieve defined goals) are needed. The short-term task is to make sure that needed services and supports are available for young people. If the neighborhood is lacking in safe places for young people to go and productive activities for them to engage in after school and on weekends, then such places need to be created. The challenge is to respond to the short-term needs of youth in ways that strengthen rather than undermine families and communities ability to create a "natural" web of supports.

The long-term task is to help families, neighbors, and communities support young people and the environments in which they grow. This requires an investment not in short-lived, problem-specific programs, but in community organizations, in civic, cultural and neighborhood associations, and in the larger economic, physical, and social infrastructures. Funders, for example, should be prepared to invest as much in strengthening the administrative, staffing, and financial capacity of community organizations as they are in strengthening particular program areas (e.g. violence prevention). And both funders and community organizations should be prepared to assess what is needed to promote the development of all youth in the neighborhood, not just those youth who join or use particular programs.

How often have we heard youth organizations lament that they can get short-term, targeted funding for substance abuse prevention, or gang intervention but struggle to support the core programs (e.g. recreation, outreach), maintain the facility and train and reward the staff? How often have we seen lists of programs working in communities but still seen scores of young people on the

streets, many of whom are unaffiliated with any program or institution?

When introduced or developed in communities, programs should follow one of two roads. They should either become a part of the community -- permanent, indigenous institutions -- or they should work to strengthen the families, neighbors, and community institutions sufficiently so that the program is no longer needed.

The mistake that we all too often make is to come in, put the program in place and believe it will solve the problem. With full understanding of the constraints involved, I have to argue that none of us -- advocates, policy makers, funders, researchers, service providers -- are working as hard to make these things happen as a natural part of family and community life as we are to create them artificially within programmatic walls.

Youth Development: Putting Theory into Practice

In the past decade, how we think about supporting young people at both the policy and the practice level has undergone a radical shift. A great number of youth funders, policymakers, and service providers are now concentrating on promoting the over all healthy development of young people instead of "fixing" specific problem behaviors through programmed solutions. While the significance of this shift in thinking in terms of principles, theory, and values has become increasingly clear, we continue to explore how these values and principles are put into practice and what types of specific changes are required throughout the system—at program, organizational, policy and funding levels—in order to effectively support young people's development.

This paper reflects the work of the Community Network for Youth Development (CNYD) in close partnership with youth development researchers Michelle Gambone and James Connell[1], and with youth agencies, public institutions, policymakers and the funding community throughout the San Francisco Bay Area. In the following pages, we provide an historical context for understanding this shift to a youth development approach and hope to consider some of its implications, both for practice and for larger system change.

The Deficit Approach

Over the past forty years, economic changes have eroded the base of social support available for young people. With the erosion of support for youth, we began to see a rise in problem behavior: increased youth violence, drug and alcohol abuse, higher school failure and drop out rates, and teen pregnancy. Driven by escalating citizen concern over these problems, policymakers began calling for programs targeted to address these specific behaviors. This approach called for intervening when young people had problems, or for identifying those young people "at risk" for problems and trying to prevent them from engaging in specific negative behaviors.

This narrow focus on young people's "deficits"—their participation in or potential for problem behavior—led to the creation of a youth services system that has been largely fragmented and comprised of programs focused on isolated problems. As in the traditional Western medical model, practitioners have sought to identify and isolate particular problems or behaviors and treat or inoculate young people against them. Program success has been defined as the reduction of these specific behaviors in the target population. Furthermore, this approach has divided young people into two groups, those exhibiting problems or at high risk for problems and everyone else; and instead of providing *more* supports for youth at higher risk, our focus on isolated problems has led us to provide *different* supports for this group.

The Shift to a Youth Development Approach

Resiliency research has provided a compelling rationale for shifting to a youth development approach in policy and practice. First, as long term evaluations of these "deficit" focused programs became available, it was clear that single programs rarely achieved the success they envisioned in eliminating problem behaviors. Second, long-term studies of youth raised in high-risk environments had consistently documented that a majority of these young people grew up not only avoiding involvement in problem behaviors, but developing into healthy and successful adults. This body of research also --and most importantly--clearly identified the environmental supports and opportunities that tipped their lives from risk to resilience. Resiliency research shifted our attention to the larger environment surrounding young people, asking what this environment must provide to enable young people to succeed. We began to more closely examine the role of the different layers of support and influence surrounding young people:

their families, schools, and communities. Research on resiliency consistently underscored the importance of caring relationships, high and positive expectations, and opportunities for participation and contribution in all of these settings: home, school, and community.[2]

The Center for Youth Development and Policy Research (CYD)[3], under Karen Pittman's[4] leadership led this movement. CYD launched a national mobilization campaign designed to transform concern about youth problems into public commitment to youth development. Academic research, such as Milbrey McLaughlin's[5] ten year study examining the roles of community based organizations in promoting youth development, also helped shift thinking in the field. Public/Private Ventures[6] and the Search Institute, further fortified the research and evaluation base by developing and evaluating large scale youth development demonstration projects.

These groups have successfully influenced policy nation wide. As the 1990's ends, local and national foundations have adopted youth development principles. State departments such as education and human services, have begun shifting from strictly categorical funding to supporting broader based youth development efforts. Federal agencies such as the Department of Health and Human Services and the Office of Juvenile Justice and Delinquency Prevention have embraced the approach and shifted research and program dollars toward community supports for youth development. Even historically risk-focused federal efforts such as the Center for Substance Abuse Prevention and Safe and Drug-Free Schools and Communities have responded to the compelling research on resilience and to the pressure from practitioners to implement a more positive—and effective—approach. A large scale movement toward a new way of working with young people was underway.

Youth Development: Theory Applied to Practice

Young people are seen as active participants in their ongoing development process which, rather than occurring "in a vacuum," is naturally influenced by the young person's environment and the supports they receive from family, peer group, school, and the larger community. Shifting to a youth development approach means that, as a field, we redefine our vision of success. We no longer defined success in terms of the prevention or elimination of negative behaviors, but in terms of young people's healthy development. And while we continue to employ a wide range of measures of young people's success in transitioning to adulthood, as a field we agree on the ultimate long term outcome we want for all young people:

> A successful transition to adulthood, where young people are able to support themselves financially, engage in healthy family and other social relationships, and contribute to their self-defined community.

But what are the implications of shifting to this long term outcome for the youth service system? It effects how we work and how we measure our success. This calls for change at all levels of the system—youth programs, youth organizations, and policymakers and funders.

Youth Development Practice at a Program Level

Youth practitioners need to employ strategies that create positive developmental environments. We know from research that environments promoting healthy development must offer young people positive relationships and experiences to:

- gain social support and caring from adults and peers, a sense of belonging and a sense of physical and emotional safety;
- have input into decision-making and to take on meaningful leadership roles;
- become involved in the larger community, giving young people a sense of contributing and broadening their knowledge of their community; and
- expose young people to a wide range of challenging and interesting learning experiences, which build an array of skills and competencies—cognitive, health, and employment.

And how do we know that these strategies have an impact on young people? In a successful youth development program, young people report that, through their participation, they:

- develop positive relationships with adults who provide them with guidance and emotional support;
- have meaningful roles with responsibility;
- feel that they contribute to their self-identified community (whether school, agency, or broader community);
- are challenged by activities that help them grow; and
- master new skills.

To successfully implement youth development practice requires professional support and resources. Youth workers must have professional support through effective training and supervision to strengthen their skills. They must also build the capacity for self-assessment, in order to reflect on and continuously improve their practice. In this way we are able, as a field, to demonstrate and be accountable for the impact our work has on young people. Far too often we fail to realize that even the most skilled of practitioners cannot succeed without these concrete supports available from their organizations. Below we outline some of the key resources and structures which organizations must have in place in order to support quality youth development practice.

Youth Development Practice at an Organizational Level

For organizations to effectively support their practitioners in creating positive developmental environments for young people, there must be a shared vision and commitment to developmental practice throughout the organization. Everyone in the organization, executive director, board and all staff, must agree on what constitutes effective youth development practice and appropriate developmental outcomes. Concrete structures and practices must be put in place to help practitioners help young people meet these outcomes. Without the support of an organization, those attempting to change practice will ultimately fail. In order to succeed, organizations need to provide training focused on building skills, provide supervision, and facilitate practitioners reflection of various strategies to improve program. Other examples of organizational practices furthering developmental practice include providing :

- low youth to staff/volunteer ratio;
- safe, reliable, and accessible spaces;
- continuity and consistency of care; and
- on-going results based staff and organizational improvement processes.

Putting these structures in place requires organizational leaders to re-examine their management structures and how they allocate their human, physical and financial resources. An organization's success in supporting developmental practice can be measured, not only through their achievement of better outcomes for young people, but through their progress in putting these concrete structures in place to enable quality practice.

Just as individual practitioners need organizational support in order to be effective in developmental practice, organizations also need the support of the larger system to be able to offer young people the supports they need. To secure such support, organizations must be able to articulate how their structures support developmental practice and what their impact is on young people.

Youth Development Practice at the Policy and Funding Level

Embracing a youth development approach at a systems and community level means creating a coherent youth policy centered around providing young people with continuous developmental support and learning opportunities across institutions throughout a young persons life. *National, state and local policy makers are ultimately accountable for ensuring that such a continuity of support exists for young people, so that they are fully prepared for adult life.* These decision makers must forge the necessary systems accommodations and ensure the flexibility of funding needed to meet these ends.

To support youth development work at the program level, funders and policymakers must consider not only what constitutes high quality youth development, but also what organizational support this work. Funding must:

- be flexible and long-term to provide organizational and program stability;
- target the organization, not just the program;
- support the creation of youth development assessment and evaluation tools, and training to build the capacity of youth workers; and
- support professional development resources for youth workers.

The success of funders and policymakers in supporting developmental practice can be judged by the number of young people in a community prepared for productive adulthood. This requires the establishment of public-private partnerships, agreement on clear expectations and outcome measures, and the development of flexible funding streams to build capacity within communities.

Conclusion

Adopting a youth development approach requires nothing short of the re-alignment of the entire system. We must share a unified vision, not only of our ultimate long term goal, but also of what constitutes developmental practice and what appropriate short term developmental outcomes are for our young people. All of us--practitioners, organization leaders, funders and policymakers—have an equal responsibility to work within our own arenas to refocus our efforts on promoting, and strengthening supports and opportunities for our young people.

The Community Network for Youth Development (CNYD) is a non-profit organization that provides technical assistance, training, and resources to strengthen the field of youth development throughout the Bay Area. CNYD also serves as a technical assistance intermediary for the San Francisco Beacon Initiative, a city-wide partnership to establish youth development centers in schools throughout San Francisco.

To contact CNYD: 657 Mission Street, Suite 410, San Francisco, CA 94105 / (415) 495-0622.

Endnotes

1. Bonnie Benard, "Research Support for Resilience-Based Prevention" (Resiliency Associates, 1997).

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Linking Prevention and Development: A Statewide Program Revitalizes Itself

By Maureen A. Sedonaen and Monica Alatorre, of the Youth Leadership institute

Current research indicates that problem-oriented prevention programs have limited or no effectiveness in influencing the decisions young people make regarding Alcohol, Tobacco and Other Drug (ATOD) use (Brown, et al., 1985). Furthermore, programs that have been both effective in minimizing use and influential in changing youth behaviors in other problem areas utilize a youth development approach that provides support and opportunities and meets the developmental needs of youth. For the last three years, the Youth Leadership Institute has worked closely with California's premiere youth prevention program, Friday Night Live. In 1999, the California Friday Night Live Partnership (CFNLP) embarked upon an ambitious process to link effective prevention strategies with positive youth development research and "best practices." Today, CFNLP's mission is firmly grounded in youth development principals, which has brought about a shift in focus from a "youth as problems" to a "youth as resources" perspective (Unlocking FNL's Potential, 1999). Consequently, Friday Night Live programs statewide are beginning to deliver programs that (1) promote youth driven practices; (2) foster autonomy, safety, community and youth-adult partnerships; and (3) demonstrate cultural and civic competency. These changes are part of a growing movement across the country – and this is good news for the nation's young people. It is heartening that, yes, even DARE is adopting a new strategy! (Anti-drug program says it will adopt a New Strategy, NY Times, February 15, 2001) DARE has decided to emphasize changing "social norms" among students rather than changing individual behaviors. DARE and others would do well to look to and follow the leadership of the California Friday Night Live Partnership in this important development. For the last 17 years CFNLP has engaged millions of youth in engaging skill building and in vital community connections which are changing not only *youth* social norms but *community norms* as well. They are doing more than just preventing serious problems among youth – they are building the skills and competencies of youth and preparing them for success.

In prevention, we continue to be concerned about youth alcohol, tobacco and other drug use; therefore, we must energetically pursue a course of action that promotes healthy choices and challenges community environments. We have learned over the last decade that ATOD is often the thread that runs through other problem areas in the lives of young people and their families. Whether it's mental, physical, or high-risk behavioral problems facing youth, alcohol and other drugs are predominantly in the mix.

CFNLP is achieving its Standards of Practice by utilizing Youth Development-based prevention strategies in middle schools, high schools, and community-based organizations. In these settings, CFNLP creates high impact, effective and comprehensive county-wide programs that include information dissemination, education, alternative activities, community-based processes, environmental prevention, and youth driven evaluation strategies. They are accomplishing this after many months of deliberate strategic planning, involving youth and adult allies throughout the state. Their progress can be a model for programs around the nation seeking to implement successful and positive prevention programs. If interested organizations follow their example, if they train staff, build community networks that support the transition, and articulate outcomes that link prevention and development, then they will successfully infuse their work with a research and outcomes based approach.

We must be bold and strategic on a national, statewide, and local level to bring these standards to all of the organizations and institutions that impact the lives of young people. We must build a network of prevention organizations that are promoting positive youth development and that have the capacity to share their expertise. We must promote proven best practices across communities to ensure outcomes that lead to productive and involved citizens. If we want young people to contribute to our society in a meaningful and sustained way, then we need to be aware that keeping them from harm is only half the work. We must follow the example of organizations like the California Friday Night Live Partnership and acknowledge that young people need to be **BOTH** problem free and fully prepared!

Maureen Sedonaen is the Executive Director of the Youth Leadership Institute, the Vice-Chair of the California Prevention Collaborative (CPC), and the Chair of the CPC's Youth Development Plank. Monica Alatorre is the Director of Communications for the Youth Leadership Institute.

3. Understand that change is a people process

While you must have a vision, a sense of mission if you will, successful change necessitates that we understand—and act on this understanding—that it is at the interpersonal level that change will actually occur. As one practitioner phrases it, "You can't shake hands with an organization!" As practitioners, we must follow the "garbage-can" method of social change: We must start where we're at with what we've got! This usually means working with some people who aren't easy to work with. As Roger Fisher and Scott Brown emphasize in their book, *Getting Together: Building Relationships as We Negotiate*, we will not get what we want unless we are willing to build relationships with those we deal with. Furthermore, successful collaborations and successful organizations—including schools—have clearly been shown to pay attention, first and foremost, to people issues.

Besides the utility of paying attention to the people process, it is also the people relationships that will keep you going as a change agent. The following quote from a letter written to a young activist by the theologian Thomas Merton illustrates this point:

"Do not depend on the hope of results. When you are doing the sort of work you have taken on...you may have to face the fact that your work will be apparently worthless and even achieve no result at all, if not perhaps results opposite to what you expect. As you get used to this idea, you start more and more to concentrate not on the results, but on the value, the truth of the work itself. And there, too, a great deal has to be gone through as gradually you struggle less and less for an idea and more and more for specific people. The range tends to narrow down, but it gets much more real in the end; it is the reality of personal relationships that saves everything."

And as several successful change agents like Michael Carrera in New York City or Marian Wright Edelman of the Children's Defense Fund point out, saving one child, one person, is success. Michael Carrera states, "We can only go so far in saying, 'The government is the enemy'; then we must roll up our sleeves, get in the trenches, and save one kid!"

4. Create caring relationships

Not only do successful change agents acknowledge that change is a people process, they understand that a caring relationship with their clientele is the key to change. The research on protective factors is loaded with examples of the power one caring teacher or adult has to change the life trajectory, the outcome for a child. Concomitantly, other investigators of why kids drop out of school clearly identify the lack of caring as a major reason. Furthermore, Lisbeth Schorr's research into successful prevention programs, especially those focused on family support, identified caring staff as a critical ingredient.

5. Believe that everyone has the innate capacity for mental health and well-being

This attitude accounts for 85 percent of successful planned change, according to one longtime community developer of longtime experience. What we're talking about here is an attitude of mutual respect that is positive, encouraging, and nonjudgmental. As community psychologist Roger Mills states, "Everyone is doing the best they can," and Michael Carrera operates on the principle that "All kids are basically good." Furthermore, this attitude includes having and communicating high expectations for our clientele. Not only is this principle validated in educational research through successful programs like Henry Levin's Accelerated Schools program and Robert Slavin's Success for All model, but research into the protective factors in the family, school, and community environments clearly identifies the strength of this attitude to empower individuals to believe that, yes, they can achieve; that, yes, they can have a bright future.

6. Elicit the active participation of those involved

Perhaps no principle is cited more often in the community development literature on promoting success. Local ownership is critical. Furthermore, we can see evidence that it works in the success of self-help support groups, cooperative learning environments, peer helping groups, collaborative teaching environments, indigenous parent educators, and so on. We also know that active participation is a major protective factor—people feel bonded to what they feel part of, to what they are involved in. Active involvement is the remedy for alienation!

7. Be committed and patient

Michael Carrera says anyone who's into helping kids had better be prepared for the "long haul" with "patient endurance" to outlast the kids. Similarly, Roger Mills, in beginning his work in the Modello

Housing Project in Miami, says he "just would not go away!" What we're talking about here is a good, old-fashioned community organizing process that takes time and nurturing.

What we see, then, is really a spiral in which we involve more and more people: By believing in our own abilities to effect change, by understanding that change is basically an interpersonal process that requires creating a caring relationship with those we work with, by having a vision and sharing that vision with others, by believing in the power of others to change, by actively involving others in the change effort, and, finally, by being patient and committed to your effort, you will be successful. You will become part of a spiraling process of broader community change.

Marian Wright Edelman, president of the Children's Defense Fund, says: "Enough committed fleas biting strategically can make even the biggest dog uncomfortable and transform even the biggest nation."

Do we really have a choice?

From *Western Center News*, March 1992, Vol. 5, No. 2

WHAT DO YOUNG PEOPLE NEED FROM US?

PROMOTE TRUE HISTORY

Young people need information about theirs and others cultural, ethnic and gender struggles and achievements. True history helps us to think of ourselves as a community responsible for one another's well being.

- ***Pay attention to cultural references. Are any groups being excluded? Are young people using assumptions and stereotypes when discussing youth or any particular group of youth? Challenge them with a simple, "why do you say that?"***

BE A PARTNER

Young people need us to be willing to share the power and work with them.

- ***Encourage adults to talk about next steps in terms of involving youth. If they are talking about an existing decision-making group, encourage them to think of how to bring youth into the process, either permanently or in a short-term advisory capacity.***

CELEBRATE THEIR SUCCESSES

Every day, young people make dozens of choices to value their own thinking, relationships, preferences and desires. These are all victories. They deserve adult allies who notice and point out these acts of self-determination, and celebrate them.

- ***Encourage young people to talk about their success stories, and encourage them to go back into their communities and look for and promote other young people's successes.***

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POINT 8: Overcome legal barriers.

Most states' laws are silent on the issue of youth serving in governance positions. Where laws do exist, they generally speak to youth on boards of directors or youth as incorporators of organizations. The issue of legal liability and youth can sometimes seem daunting, but with proper precautions it can be easily managed.

POINT 9: Make your meetings interactive.

Activities like "go arounds" and "brainstorms" ensure that everyone has a voice in the decision making process. They create a dynamic environment that will engage all of your members and are critical to involving youth.

POINT 10: Meet with and mentor younger leaders.

For youth to be full and active participants, they need time to prepare for meetings and to evaluate and discuss them afterwards. Adult leaders or staff members should meet with young people for a few minutes before meetings and after meetings.

POINT 11: Involve young people in visible leadership positions.

Committee positions and other visible leadership roles should include young people as frequently as possible. Involving youth deeply in governance fosters their fullest participation and ensures that they are included in important between meeting business.

POINT 12: Network young leaders with their peers.

Set up systems and situations for young people to network. If there are other local young people in leadership positions bring them together on occasion to discuss their work, learn new skills, and support one another. This kind of networking re-energizes youth from your organization and introduces them to the larger youth governance movement.

POINT 13: Network adults who support young leaders.

If there are other organizations with young people in leadership positions in your area, gather together executive directors and adult board members to discuss their successes and struggles with involving youth.

POINT 14: Accommodate young people's special situations.

Special situations will arise when involving young people. A board should be flexible by accommodating school schedules and transportation difficulties. Family commitments and extracurricular activities deserve the same consideration as adults' work trips, vacations, and flat tires.

Developed By: Youth on Board, Summerville, MA.

Youth Leadership Institute

The Youth Leadership Institute is a community based institute which joins with young people to build communities which respect, honor and support youth. YLI reaches out to youth who have not traditionally been viewed as leaders and involves them in shaping community change. YLI is recognized nationally as a leader in the field of youth development, particularly in the areas of environmental prevention, youth philanthropy, youth in governance, and youth-driven policy work.

Training & Technical Assistance

The Youth Leadership Institute provides professional, relevant, effective training and technical assistance to youth, youth practitioners, & policy makers in order to share information and promote best practices in youth development. YLI trainings are grounded in our belief that young people themselves are best able to identify the issues which concern them and to identify solutions. We deliver trainings in partnership with young people whenever possible.

Programs

San Francisco Friday Night Live & Club Live
Marin Friday Night Live & Club Live
San Mateo Friday Night Live & Club Live
Youth Taking Charge
Youth Initiated Projects
Youth Grants Board
Marin County Youth Commission
Young Active Citizens

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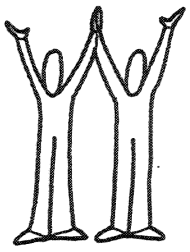

Additional Teen Pregnancy Prevention Articles and Websites

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"U.S. Teenage Pregnancy Statistics with Comparative Statistics for Women Aged 20-24". The Alan Guttmacher Institute, New York and Washington. Updated February 19, 2004. http://www.guttmacher.org

"U.S. Teenage Pregnancy Statistics, Overall Trends, Trends by Race and Ethnicity and State by State Information." The Alan Guttmacher Institute, New York and Washington. Updated February 19, 2004. http://www.guttmacher.org

"Young Men Moving Forward: California's Male Involvement Program, A Teen Pregnancy Prevention Program for Males". Monograph. http://dhs.ca.gov/ofp